MEDICAL HISTORY (CHECK ALL THAT APPLY) **Name:**___________________________

PLEASE STATE CURRENT FOOT OR ANKLE PROBLEMS: ____
____

ANY ALLERGIES: ☐NO DRUG ALLERGIES ☐ADHESIVE TAPE ☐ ANTI-INFLAMMATORIES (IBUPROFEN, ETC) ☐LATEX ☐ IODINE
☐ANTIBIOTICS:______________________ ☐PAIN MEDICATION:__________________________ ☐ANESTHETIC:________________________
☐ OTHERS:____

LIST ANY MAJOR SURGERIES OR PROCEDURES AND ANY INJURIES OR FRACTURES YOU HAVE HAD (ALL BODY PARTS):

YEAR	SURGERY/PROCEDURE	YEAR	INJURY/FRACTURE

MEDICATIONS: LIST CURRENT MEDICATIONS, INCLUDING DOSAGES

____
____
____
____

EMERGENCY CONTACT: ____
PHONE:____
PREFERRED PHARMACY:_____________________________________
PHONE:____

HEALTH HISTORY (CHECK ALL THAT APPLY):

☐ PACEMAKER
☐ HEART ATTACK
☐ ASTHMA
☐ HYPERTENSION
☐ DIABETES MELLITUS
☐ ARTHRITIS
☐ HEPATITIS
☐ BLEEDING PROBLEMS
☐ CANCER
☐ NEUROPATHY
☐ ALZHEIMERS
☐ LOSS OF VISION
☐ HEARING LOSS
☐ ANESTHESISA PROBLEMS
☐ CHEST PAIN
☐ CRUSHING CHEST PAIN
☐ CONGESTIVE HEART FAILURE
☐ ARTIFICIAL HEART VALVES
☐ PALPITATIONS
☐ ANGINA
☐ HEART DISEASE
☐ BACK PAIN
☐ DIFFICULTY BREATHING
☐ SHORTNESS OF BREATH
☐ DIALYSIS
☐ LIVER DISEASE
☐ KIDNEY PROBLEMS
☐ URINE FREQUENCY
☐ URINE URGENCY
☐ URINE ODOR (ABNORMAL)
☐ EXCESSIVE SWEATING
☐ NIGHT SWEATS
☐ SLEEP APNEA
☐ STROKE
☐ HIGH CHOLESTEROL
☐ LEG PAIN W/ EXCERSICE
☐ MUSCLE CRAMPS
☐ TINGLING
☐ NUMBNESS
☐ VERTIGO
☐ FAINTING
☐ PARALYSIS
☐ SEIZURES
☐ BALANCE PROBLEMS
☐ ARTIFICIAL JOINTS
☐ ULCERS
☐ DRY SKIN
☐ SKIN DISCOLORATION
☐ TUBERCULOSIS
☐ RECENT WEIGHT LOSS
☐ RECENT WEIGHT GAIN

HEALTH HABITS : HEIGHT________ WEIGHT________ SHOE SIZE_______ HOSPITAL PREFERENCE_________________________________
DAILY CAFFINE INTAKE________________________ SLEEPING HABITS___________________________ LIVE ALONE?__________

TOBACCO	**DO YOU USE TOBACCO?** ☐ YES ☐ NO ***IF YES*: CIGARETTES** - HOW MANY PACKS/DAY? _____ **CIGARS** - #/WEEK?_____ **SMOKELESS TOBACCO** - CANS/WEEK? _____
ALCOHOL	**DO YOU DRINK ALCOHOL?** ☐YES ☐NO ***IF YES***: WHAT FORM AND HOW OFTEN? ________________________________ **DO YOU USE RECREATIONAL DRUGS?** ☐YES ☐NO ***IF YES***: WHAT FORM AND HOW OFTEN? ____________________________
INJECTIONS	**DATE OF LAST FLU SHOT? ____ /_____ /__________ DATE OF LAST PNEUMONIA SHOT? ____ /_____ /__________**
ACTIVITY	**HOW OFTEN ARE YOU ON YOUR FEET DAILY?** ________________________________ ☐10% ☐25% ☐ 50% ☐75% ☐90%

FAMILY MEDICAL HISTORY: LIST ANY SIGNIFICANT HEALTH PROBLEMS THAT YOUR BLOOD RELATIVES HAVE HAD (*ex:heart* disease*,diabetes,foot conditions)*
☐ *Check here if you are adopted or if you do not know your family medical history*

MOTHER	
FATHER	
SIBLINGS	