Medical History

Name_____Date_____
EXPLAIN YOUR FOOT /LEG COMPLAINTS
_____
_____
Primary Care Physician_____Last Exam Date_____
Previous surgeries:_____
Medications Being Taken:_____
_____
CHECK ANY OF THE FOLLLOWING CONDITIONS THAT YOU HAVE/ HAD:
_____Congenital Heart Disease _____Cardiovascular Disease
_____High Blood Pressure _____Poor Circulation
_____Stroke _____Fainting Spells
_____Diabetes _____Hepatitis
_____Liver Problems _____Jaundice
_____Kidney Problems _____Stomach Ulcers
_____Arthritis _____Aids
_____Gout _____ Blood Clots
_____Venereal Disease _____Cancer
_____Others (please list)
_____
_____
Do you bruise or bleed easily?____Do you have any blood disorders such as anemia?_____
Have you ever had foot/ ankle surgery?_____When?_____By whom?_____
Have you ever had any complications or serious problems with previous treatment?_____
Please explain_____
When you cut yourself, do you heal easily?_____Do you smoke?_____
Do you drink?_____How much?_____What is your shoe size?_____
What is your weight?_____Women-are you pregnant?_____
ARE YOU ALLERGIC OR ADVERSELY AFFECTED BY ANY OF THE FOLLOWING:
_____Local Anesthetics _____Penicillin _____Anitibiotics
_____Sulfa Drugs _____Barbiturates _____Sedatives
_____Sleeping Pills _____Iodine _____Codeine
_____Topical Solutions _____Adhesive Tape _____Mole Skin
_____Felt or Glue _____Other_____
_____