MEDICAL HISTORY HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

REASON FOR YOUR VISIT: _____

MEDICATIONS: _____

_____

DO YOU SMOKE? NO_____ YES_____ #PACKS PER DAY: _____ PREVIOUSLY SMOKED? N Y # OF YEARS: _____

ALCOHOL INTAKE: NO_____ YES_____ QUANTITY: _____

PLEASE CHECK THE APPROPIATE BOXES. I HAVE OR HAVE HAD THE FOLLOWING:

PODIATRIC CONDITIONS:

- ☐ ANKLE PAIN
- ☐ ATHLETE'S FOOT
- ☐ BUNIONS
- ☐ CORNS AND CALLUSES
- ☐ NUMBNESS IN FEET OR LEGS
- ☐ FLAT FEET
- ☐ FOOT OR LEG CRAMPS
- ☐ HEEL PAIN
- ☐ INGROWN TOENAILS
- ☐ PLANTAR WARTS
- ☐ SWELLING IN ANKLES/FEET
- ☐ DIABETIC FOOT EXAM

MEDICAL CONDITIONS:

- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERTENSION DISORDER
- ☐ KIDNEY DISEASE
- ☐ LUNG DISEASE _____
- ☐ LIVER DISEASE _____
- ☐ AIDS/HIV
- ☐ ARTHRITIS
- ☐ BACK PROBLEMS
- ☐ BLEEDING DISORDERS
- ☐ CANCER _____
- ☐ CHEMICAL DEPENDENCY
- ☐ CIRCULATORY PROBLEMS
- ☐ LUPUS
- ☐ Hep C
- ☐ FAINTING
- ☐ GOUT
- ☐ HEMOPHILIA
- ☐ LOW BLOOD PRESSURE
- ☐ NEUROPATHY
- ☐ PHLEBITIS
- ☐ RHEUMATIC FEVER
- ☐ STROKE
- ☐ ULCERS
- ☐ VARICOSE VEINS
- ☐ VENEREAL DISEASE
- ☐ WEIGHT LOSS, UNEXPLAINED
- ☐ PREGNANT

ALLERGIES:

- ☐ ASPIRIN
- ☐ IODINE
- ☐ NOVOCAINE
- ☐ ADHESIVE
- ☐ CODEINE
- ☐ PENICILLIN
- ☐ SULFA
- ☐ OTHER ALLERGIES: _____
- ☐ **NO** KNOWN DRUG ALLERGIES