MEDICAL HISTORY INFORMATION

Please explain the reason for your visit. **(In Detail)**_____

_____

How long have you been bothered by this condition? _____Days _____ Weeks _____ Months _____ Years

Have you ever been treated for this condition before? ☐Yes ☐No

If **YES** by whom Name:_____ Date: _____

Name: _____ Date: _____

If **NO** what have you used to improve the symptoms? _____

_____

Have you ever had any previous **FOOT** surgeries? ☐Yes ☐No

Name: _____ Procedure: _____ Date: _____

Name: _____ Procedure: _____ Date: _____

Have you ever been hospitalized in the past five years? **(Other than Surgery)**_____

_____

Have you ever had orthotics?_____

Are you allergic to any medications, foods, tape, latex etc..?_____

Are you taking any Medications, Vitamins, Herbs, Cold pills, Remedies, Stimulants, Steroids, Birth control, Diet pills, Non-traditional medicines, Over the counter medicines, etc..? **(Explain all that apply)**_____

_____

Do you smoke Cigarettes? ☐Yes ☐No If Yes how much and how long._____

Do you drink Alcohol? ☐Yes ☐No ☐Occasionally

Do you use Recreational Drugs? Marijuana, Cocaine, Crack, Heroin, Ecstacy, GHB, Mushrooms, LSD, Speed, etc..

(Explain all that apply)_____

PLEASE CHECK THE APPROPRIATE BOXES THAT APPLY TO YOU.

☐ ARTHRITIS	☐ KIDNEY DISEASE	☐ STROKES
☐ ASTH MA	☐ THYROID DISEASE	☐ HEPATITIS B OR C
☐ CANCER	☐ DIABETES	☐ PSYCHIATRIC ILLNESS
☐ HEART DISEASE	☐ SICKLE CELL TRAIT/ANEMIA	☐ VARICOSE VEINS
☐ HEART ATTACK	☐ HEMOPHILIA	☐ KELOIDS
☐ STOMACH ULCERS	☐ HIGH CHOLESTEROL	☐ LEG/FOOT ULCERS
☐ HIGH BLOOD PRESSURE	☐ VASCULAR DISEASE	☐ BLEEDING DISORDERS
☐ RASHES	☐ PULMONARY EMBOLUS	☐ CATARACTS
☐ SEASONAL ALLERGIES	☐ HIV	☐ HYPERTROPHIC SCARS

PLEASE EXPLAIN ALL CHECKED ANSWERS._____

_____