Medical Information

Describe your foot problem

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How long has it been bothering you:____

Shoe size______________ Weight____________ Height________________________________

Medical History: Please list any medical problems

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Review of Organ Systems: Place an (x) if you have any of these problems

( ) weight gain
( ) headaches
( ) dizziness
( ) heart murmers
( ) stomach ulcers
( ) diverticulitis
( ) back pain
( ) skin rashes
( ) memory loss
( ) thyroid disease
( ) renal failure

( ) weight loss
( ) blurred vision
( ) neck stiffness
( ) emphysema
( ) gastric reflux
( ) rectal polyps
( ) rheumatoid arthritis
( ) tingling in your feet
( ) depression
( ) osteoporosis
( ) kidney stones

( ) fatigue
( ) glaucoma
( ) chest pain
( ) asthma
( ) hepatitis
( ) gallbladder problems
( ) knee pain
( ) numbness in your feet
( ) insomnia
( ) anemia

( ) nausea
( ) hearing loss
( ) hypertension
( ) chronic cough
( ) chronic diarrhea
( ) pancreatic problems
( ) hip pain
( ) seizures
( ) diabetes
( ) bladder problems

Medication List

Name of the drug	Strength (ex mg.)	number of times

Allergies:

List the names of any medications that you know you are allergic to:

Surgical History:

List the type of surgery:

Family Medical History:

Is there a family history of:

Bunions ___ Hammertoes____ Flat feet_____ High Arches_______ Diabetes___________

Mother: Living______Deceased______Cause of Death________________________Age______
Father: Living______Deseased______Cause of Death________________________Age______

Do you Smoke? No_________Yes__________# packs per day__________# years
Previously smoked? If so when did you quit___________years ago

Do you drink alcohol? Yes_________ No______
If yes, ( ) 1-2 drinks per week ( ) 1-2 drinks per day ( ) more than 2 drinks per day