Patient Information

First Name	MI	Last Name				Occupation	I prefer to be addressed as: ☐ By my first name. ☐ Nick Name:_____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Age	Date of birth / /	Sex	Height	Weight	Shoe Size	Percentage of time spent on your feet daily? *(Please circle)* 20% 40% 60% 80% 100%	
Activities and exercise in which you participate							
Primary Dr.	City	Phone #	Last visit			Preferred Pharmacy	Location & City / Phone #

Comprehensive Patient Medical History

Have you had/been treated for: *(Please check all that apply)*

- ❑ Ankle/foot sprain
- ❑ Arch pain
- ❑ Bunions
- ❑ Broken foot bone(s)
- ❑ Childhood foot problems
- ❑ Corns/Calluses
- ❑ Cramps in legs/feet
- ❑ X-rays of feet
- ❑ Flat feet
- ❑ Foot numbness
- ❑ Gout
- ❑ Fungal Nails
- ❑ Hammer (curled) toes
- ❑ Heel pain
- ❑ High arch feet
- ❑ Ingrown nails
- ❑ Joint pain
- ❑ Knee pain
- ❑ Lower back pain
- ❑ Neuroma
- ❑ Athlete's foot
- ❑ Warts
- ❑ Other _____ _____

Have you worn or currently wear orthotics? Y / N How long? _____
Where were the devices obtained? _____

Do you have or have you ever been treated for: *(Please check all that apply)*

- ❑ Anemia
- ❑ Alcohol abuse
- ❑ Alzheimer's
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Blood Clots
- ❑ Bursitis
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug abuse
- ❑ Epilepsy/Seizures
- ❑ GI bleeding
- ❑ Heart condition
- ❑ Heart attack
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lung disease
- ❑ Poor circulation
- ❑ Psychiatric Disorder
- ❑ Rheumatic fever
- ❑ Stomach disorders
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Vascular disease
- ❑ Other _____

Do you have:

- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Implant
- ❑ Pace-maker
- ❑ Prosthesis

Are you pregnant? ❑ Y ❑ N Months _____
Do you smoke? ❑ Y ❑ N Packs/day _____ Years _____
Did you ever smoke? ❑ Y ❑ N Packs/day _____ Years _____
If you quit, when did you do so? _____

Alcoholic beverages? ❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit
Recreational drugs? ❑ None ❑ Rarely ❑ Moderately ❑ Daily ❑ Quit
Have you ever been exposed to the HIV virus (AIDS)? ❑ Y ❑ N
Have you ever had a blood transfusion? ❑ Y ❑ N **When?**

Previous surgeries:

Surgery for	Date	Complications

Please list any medications *(including over-the-counter drugs, oral contraceptives and vitamins)* **you are currently taking:**

Medications	How often?

Allergies: *(Please check all that apply)*
If yes, what happens? *(rash, swelling, ER/Hosp, upset stomach)*

- ❑ Adhesive tape
- ❑ Environmental
- ❑ Metal

- ❑ Advil, Aleve, or Motrin _____
- ❑ Aspirin _____
- ❑ Celebrex/Vioxx _____
- ❑ Codeine _____
- ❑ Demerol _____
- ❑ Iodine _____
- ❑ Novocain _____
- ❑ Other anesthetics _____
- ❑ Other antibiotics _____
- ❑ Other pain medications _____
- ❑ Penicillin _____
- ❑ Sulfa _____
- ❑ Tylenol _____
- ❑ Any other drugs or meds _____
- ❑ **No known allergies**

Please describe your foot complaint in detail: *(Specify right/left)* _____
_____
_____

I certify that the above information is complete and accurate, to the best of my knowledge.

PATIENT OR GUARDIAN'S SIGNATURE _____ **DATE** _____