

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies to Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies to Medicine or Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rash
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	or Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in Ankles, Feet
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bronchial Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired Feet
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained
<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis			

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

ALLERGIES

<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocaine
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafoods
<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	
Other _____	

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____