

Name: _____ Date: _____
Height: _____ Weight: _____ Shoe Size: _____

What is your main foot problem? _____

When did it start? _____

Any other foot or leg problems? If so, please explain: _____

Have you ever been treated by another foot doctor? If so, please describe treatment: _____

Was the treatment successful? _____

Have you treated the problem at home? If so, please explain: _____

How is your general health? Please choose one: __Poor __Good __Excellent

How is your general nutrition? Please choose one: __Poor __Good __Excellent

Are you or have you been under a doctor's care during the past 2 years? If so, please explain: _____

Have you ever been treated for any of the following? Please check all that apply:

- | | | | |
|------------------------------------------------|--------------------------------------------|----------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Circulation Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Triglycerides | <input type="checkbox"/> Dementia | <input type="checkbox"/> Alzheimer's | |

Please list any surgeries or hospitalizations: _____

Are you pregnant? ___ Do you smoke? ___ How much? ___ Do you drink alcohol? ___ How much? ___

Please list any medications you are taking (vitamins and herbal supplements as well): _____

Are you allergic or sensitive to any of the following? Please check all that apply.

- | | | | | | |
|--------------------------------------------|----------------------------------------|---------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other: _____ | | |

Have any of your blood relatives been treated for any of the following? Please check all that apply.

- | | | | | |
|----------------------------------------|---------------------------------------|---------------------------------|----------------------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Gout | <input type="checkbox"/> Other: _____ | |