Patient Medical History

Have you ever been treated for or presently have any of the following (**check all that apply**):

□ Diabetes □ High Blood Pressure □ Hypercholesterol □ Gout
□ Heart Disease □ Liver Disease □ Stomach Ulcer
□ Poor Circulation □ Kidney Disease □ Back Pain

Please list any other medical conditions: ____

Foot Health History (**please check all that apply**)

□ Leg or Foot Ulcers □ Arch Pain □ Heel Pain
□ Broken Foot/Ankle □ Warts □ Neuroma
□ Ankle Sprain □ Fungal Nails □ Ingrown Nails
□ Pain in Calves when walking

Current Medications (**please list strengths and frequencies if known**)

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Preferred Pharmacy Name and Phone: ____

Allergies (Drug, Food, Environmental): ____

List any surgeries or hospitalizations including dates:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Do you now or did you ever smoke? Y / N Packs/day ____ # of Years ___ Year Quit ___

Alcoholic beverages? (**check one**) □ None □ Rarely □ Moderately □ Daily □ Quit

List relationship to you of family members who have had:

Diabetes _____________ Heart Disease ______________ Cancer ____________

Arthritis _____________ Foot Problems _____________

Patient Name: __________________________________ D.O.B.: _____________
Height___________ Weight___________