MEDICAL INFORMATION

This information is important for our records and your health

Describe your present foot problem: _____

_____

How long has it been bothering you? _____ Days _____Weeks _____ Months_____Years

Have you had any medical treatment for your foot/ankle problem? _____

_____

Have you had or have any of the following medical conditions, if so please ☑ the box.

☐Heart ☐ Healing ☐Arthritis ☐Kidneys ☐Lungs ☐Cancer ☐Asthma ☐ Diabetes ☐ Intestines ☐Stomach Ulcers

☐Hormones ☐Anemia ☐Bladder ☐High Blood Pressure ☐Skin ☐Gout ☐Rheumatic ☐Liver ☐Tuberculosis

☐Eye Disorders ☐Unexplained Weight Loss ☐Frequent Infections ☐ Circulation ☐Neurological Disorder

Do you have any current problems with?

☐Head ☐ Ear ☐ Eye ☐ Nose ☐Throat

Have you had any major surgeries? _____ Yes _____ No

If yes, what kind of surgery? _____

_____

Are you allergic or sensitive to any medications? Please list _____

_____.

Have you had any problems taking aspirin or ibuprofen (Advil/Motrin)? ____Yes ____No

Are you currently taking any medications? _____Yes _____No

If yes, Please list them _____

_____

Do any of your family members (Blood relatives) have any of the following conditions?

☐Heart Disease ☐Stroke ☐Hammertoes ☐Arthritis ☐Diabetes ☐Flat Feet ☐Cancer
☐Bunions ☐Bleeding Disorders ☐Neurological ☐Circulation problems legs or feet

Do you smoke? Yes_____#of packs per day _____ NO _____

Previously smoked? Yes _____ # of years No ____

Do you drink alcohol? Yes ____ How often _____ NO _____

Do you participate or have participated in illegal drug use? Yes _____ No _____

What is your current: Weight _____ Height _____ Shoe Size _____

Have you tested positive for HIV and or Hepatitis within the last six months? Yes_____ No_____