

HEALTH HISTORY
(PLEASE PRINT)

NAME: _____ Date of Birth: _____

Family Doctor: _____ Last Visit: _____

My foot problem is: _____

When did problem start & how has it been treated: _____

Any other foot problems in the past: yes no explain: _____

Do you have any of the following:

Diabetes	yes	no	Tumors	yes	no	Nervousness	yes	no
Peripheral Vascular Disease	yes	no	Gout	yes	no	Arteriosclerosis	yes	no
Leg cramps	yes	no	Glacoma	yes	no	Venereal Disease	yes	no
Cancer	yes	no	Epilepsy	yes	no	Rheumatic Fever	yes	no
Hepatitis	yes	no	Asthma	yes	no	Rheumatism/Arthritis	yes	no
Varicose Veins	yes	no	Stomach ulcers	yes	no	HIV/Aids	yes	no
Infections	yes	no	Kidney Trouble	yes	no	Bleeding Tendencies	yes	no
Fractures	yes	no	Stroke	yes	no	Tuberculosis	yes	no
Polio	yes	no	Heart Trouble	yes	no	Are you pregnant	yes	no
Anemia	yes	no	High Blood Pressure	yes	no			

What is your general health condition: _____

Is there any family history of Diabetes? _____ who? _____

Do you consume alcohol? _____ how much per week? _____

Do you smoke tobacco products? _____ how much/often? _____

Have you ever been hospitalized for any reason other than surgery? _____

If so, explain: _____

Please list all previous operations and dates:

_____	date: _____	_____	date: _____
_____	date: _____	_____	date: _____
_____	date: _____	_____	date: _____
_____	date: _____	_____	date: _____
_____	date: _____	_____	date: _____

Are you allergic to any of the following:

Adhesives/Tapes	yes	no	Iodine	yes	no	Penicillin	yes	no
Aspirin	yes	no	Mercurials	yes	no	Sulfa	yes	no
Antihistamines	yes	no	Merthiolate	yes	no	Sutures	yes	no
Codeine	yes	no	Novacaine	yes	no	Sulfides	yes	no
Demerol	yes	no	Nylon, Plastics	yes	no	Other : _____		

List medications and dosage you are currently taking (including vitamins, and herbs):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there anything else about your health that we should know? _____

