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MEDICAL HISTORY FORM

Name: ____ **Age:** _______ **Shoe Size:** __________________________

Height: ____________________ **Weight:** _______________________________

What is the chief complaint for which you came to be treated? ____

What is your level of pain? (0 no pain, 10 extreme pain) ____

Have you ever been treated for this before? ◯Yes ◯No

Have you ever been to a Podiatrist before? ◯Yes ◯No If yes, please list. **Name**: ____________________________________

MEDICAL HISTORY Place a mark on "**Yes**" or "**No**" to indicate if you have had any of the following: If yes, please explain below.

AIDS/HIV	◯Yes ◯No	Diabetes	◯Yes ◯No	MRSA	◯Yes ◯No
Respiratory Disease	◯Yes ◯No	Anemia	◯Yes ◯No	Foot or Leg Cramps	◯Yes ◯No
Arthritis	◯Yes ◯No	Gout	◯Yes ◯No	Heart Disease	◯Yes ◯No
Asthma	◯Yes ◯No	Phlebitis	◯Yes ◯No	Swelling in Ankles, Feet	◯Yes ◯No
Back Problems	◯Yes ◯No	Bleeding Disorders	◯Yes ◯No	High Blood Pressure	◯Yes ◯No
Gastrointestinal Disease	◯Yes ◯No	Cancer	◯Yes ◯No	Chemical Dependency	◯Yes ◯No
Liver Disease/ Hepatitis	◯Yes ◯No	Ulcers	◯Yes ◯No	Varicose Veins	◯Yes ◯No
Circulatory Problems	◯Yes ◯No	Phlebitis	◯Yes ◯No		

OTHER: ____
____

SURGERIES YOU HAD ____
____
____

MEDICATIONS: Include prescriptions, over-the-counter medications and vitamins ____________________________________
____
____
____

ALLERGIES:____
____

PHARMACY NAME: _____________________________ **PHARMACY ADDRESS**: ____

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**_______________________