Patient History

Name: _____ **Age:** _____

How Did You Find Out About Our Office? _____

What Is Your Foot Problem?

_____

_____

Medical/Family History:

	Self	Family	Who?		Self	Family	Who?
AIDS/HIV	❑	❑		Headaches	❑	❑	
Anemia	❑	❑		Heart Condition/Murmur	❑	❑	
Arthritis	❑	❑		Hepatitis	❑	❑	
Asthma	❑	❑		High Blood Press.	❑	❑	
Back Problems	❑	❑		Kidney Problems	❑	❑	
Bleeding Disorder	❑	❑		Liver Disease	❑	❑	
Blood Clots	❑	❑		Lung Disease	❑	❑	
Cancer (_____)	❑	❑		Nervous Disorder	❑	❑	
Cholesterol	❑	❑		Rheumatic Fever	❑	❑	
Diabetes	❑	❑		Seizure Disorder	❑	❑	
Foot/Leg Cramps	❑	❑		Sickle Cell Anem	❑	❑	
Gangrene	❑	❑		Stroke	❑	❑	
Glaucoma	❑	❑		Thyroid Problems	❑	❑	
Gout	❑	❑					

Past Surgical History:

_____

_____

_____

Medications (include prescriptions, over-the-counter medications and vitamins):

_____

_____

Are You Allergic To Anything (If So, Please List Allergy And Reaction)? ☐Yes ☐No

_____

Do You:
Drink Alcohol? _____ **Smoke Tobacco?** _____ **Use Drugs?** _____

Family Physician Name And Address:

_____

_____

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 lower extremities.

_____ _____

Patient Signature Date