

Personal Medical History

Height: _____ Weight: _____ Shoe Size: _____ Age: _____

Occupation: _____ Retired? _____ When: _____

Employment: Sedentary Stands Stands and walks

****State in your own words what your foot or ankle problem is and when did it occur?**

Have you had foot or ankle problems in the past? _____

Were you treated by another podiatrist or physician? _____

What treatment or surgery was performed? _____

Is your injury work related? _____

Name of Primary Care Doctor: _____ Date of last visit: _____

Name of Pharmacy: _____ Phone #: _____

Form of Exercise you do: _____ Days/week _____

Do you Smoke? No Yes # per day _____ Previously smoked? Yes Quit when? _____

Do you drink alcohol? Yes No Frequency(circle): 1-2 a week, 1-2 a day, 3 or more a day

For Females only: Are you pregnant? _____ How many months? _____

Do you have any artificial joints?

Hip(s) yes no date inserted: _____

Knee(s) yes no date inserted: _____

Other : _____

ALLERGY INFO: Have you had any allergic reactions or side effects to the following substances?

	YES	NO
PENICILLIN		
SULFA		
OTHER ANTIBIOTICS		
LOCAL ANESTHETICS (novocaine, lidocaine)		
ASPIRIN or IBUPROFEN(Advil, Motrin)		
CODEINE or OTHER NARCOTICS		
ADHESIVE TAPE or LATEX		
OTHER MEDICAL PRODUCT		

FOR DOCTORS ONLY

VITALS: BP _____ PULSE _____ RESPIRATION _____

PRINT NAME _____ DATE _____