

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Chief Complaint \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_

Have you been treated for this condition?  Yes  No

Have you been to a foot specialist before?  Yes  No

If yes, to whom? \_\_\_\_\_

Have you ever been treated medically for any of the following? Please Circle Yes or No

AIDS	Yes	No	Fractures	Yes	No	Respiratory disease	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Rheumatic fever	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Seizures	Yes	No
Bleeding problems	Yes	No	Heart disease	Yes	No	Stomach ulcers	Yes	No
Bowel disorder	Yes	No	High blood pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Liver disease	Yes	No	Thyroid problems	Yes	No
Circulation	Yes	No	Leg cramps	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Neurological problem	Yes	No	Warts	Yes	No
Epilepsy	Yes	No	Phlebitis	Yes	No			

Other problems? \_\_\_\_\_

Past surgeries? \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No

Current Smoker  Former Smoker  Never Smoked

Caffeine?  Yes  No

Alcohol?  Yes  No

Is there a family history of any diseases? If yes, what? \_\_\_\_\_

List all medications currently taking: \_\_\_\_\_

List all medications allergic to: \_\_\_\_\_

Any additional information we should be aware of: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_