

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR:

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|--|---|--|
| <input type="checkbox"/> STROKE <input type="checkbox"/> PHLEBITIS <input type="checkbox"/> DIABETES <input type="checkbox"/> HEPATITIS <input type="checkbox"/> GOUT <input type="checkbox"/> SCIATICA <input type="checkbox"/> ALZHEIMER'S <input type="checkbox"/> EPILEPSY <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> ASTHMA <input type="checkbox"/> CANCER <input type="checkbox"/> OTHERS: _____ | <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> VASCULAR DISEASE <input type="checkbox"/> POOR CIRCULATION <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> KELOID/THICK SCAR <input type="checkbox"/> NERVE DISORDER <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> LUNG DISEASE <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> A HEART CONDITION <input type="checkbox"/> HEADACHES <input type="checkbox"/> ANEMIA <input type="checkbox"/> OSTEOPOROSIS <input type="checkbox"/> LYME'S DISEASE <input type="checkbox"/> HEARING/EAR DISORDER <input type="checkbox"/> PHYSICIAN DISORDER <input type="checkbox"/> THYROID PROBLEMS <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> NONE OF THESE |
|--|---|--|

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| | YES | NO |
| Do you have vascular grafts? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have joint implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have replacement heart valves? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you now under active chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any other serious illness? (List) | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been hospitalized or been under medical care over 24 hours? (Explain) | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any surgery? (List) | <input type="checkbox"/> | <input type="checkbox"/> |

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| | YES | NO |
| Do you smoke now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you ever smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| If you quit, when? _____ | | |
| Alcoholic Beverages? | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational Drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take medications as prescribed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking insulin? | <input type="checkbox"/> | <input type="checkbox"/> |

SURGERY FOR: DATE: COMPLICATIONS?

LIST RELATIONSHIP TO YOU OF FAMILY MEMBERS WHO HAVE HAD:

- Diabetes _____
- Arthritis _____
- Stroke _____
- Cancer _____
- Foot Problems _____
- Heart Attack _____
- High Blood Pressure _____
- Birth Defects _____

- Are you currently pregnant? (Circle) YES NO
- # of childbirths _____
- Are you slow to heal after cuts or surgery? (Circle) YES NO
- Any abnormal bruising, bleeding, or scarring? (Circle) YES NO

ADDITIONAL INFORMATION YOU WANT US TO KNOW:

- Did you previously or do you now have:
- Shoe Inserts?(Circle) Y or N Still have? Y or N Did they help? Y or N
- Orthotics?(Circle) Y or N Still have? Y or N Did they help? Y or N
- Obtained from: (Circle) Another Podiatrist An Orthopedist
- A Physical Therapist A Chiropractor Other: _____

Today's Date ____/____/____