Name:____ Date:______________

MEDICAL/ HEALTH INFORMATION

Primary Care Physician: _____________________________ Last doctor Visit:_________________

May we contact this Physician if necessary? YES NO

Have you had previous care by a Podiatrist?	Yes	No
Have you been hospitalized during the past two years?	Yes	No
Have you been under the care of a medical doctor during the past two years?	Yes	No
Have you taken any medications or drugs during the past two years?	Yes	No
Are you allergic or made sick by penicillin, aspirin, codeine or any drugs?	Yes	No
Do you or any family members have diabetes?	Yes	No
When you walk up stairs do you ever have to stop from pain in your chest, shortness of breath, or cramping or tired feeling in your legs?	Yes	No
When you walk any distance do you get a tired or cramping sensation in your legs or feet?	Yes	No
Do your ankles swell during the day?	Yes	No

Current Height __________ Weight _________

Do You Smoke? Yes No How Much?______ How many years have you smoked?________

Do You Drink Alcohol? Yes No Describe: How often? Social occasional daily

Do you now, or have you ever in the past suffered from any of the following?

Arthritis	Yes	No
Artificial Joint	Yes	No
Asthma	Yes	No
Bleeding Tendencies	Yes	No
Blood Transfusions	Yes	No
Bronchitis/ Emphysema	Yes	No
Chest Pain/ Angina	Yes	No
Chronic Cough	Yes	No
Diabetes # of years____	Yes	No
Epilepsy/ Convulsions /Seizures	Yes	No
Fainting	Yes	No
Fast / Irregular Heart Rate	Yes	No
Glaucoma	Yes	No
Hay Fever/ Sinus Problems	Yes	No
Heart Attack	Yes	No
Heart Murmur	Yes	No
Heart Pacemaker	Yes	No
Hepatitis/ Yellow Jaundice	Yes	No
High Blood Pressure	Yes	No
HIV or Exposure to HIV	Yes	No
Kidney or Bladder Problems	Yes	No
Liver Disease	Yes	No
Pneumonia	Yes	No
Sickle Cell Disease or Trait	Yes	No
Shortness of Breath	Yes	No
Stomach Problems/ Ulcers	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Vascular Problems/Varicose Vein	Yes	No
(Women) Are you Pregnant?	Yes	No

Please list any further problems, disease or condition not mentioned above.

____

____