



3. Do you or have you ever had any of the following **MEDICAL PROBLEMS?**

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

4. Have you undergone **SURGERY?**  YES  NO

TYPE OF SURGERY \_\_\_\_\_

DATE \_\_\_\_\_

5. **SOCIAL HISTORY**

MARITAL STATUS:  SINGLE  MARRIED  PARTNERED  SEPARATED  DIVORCED  WIDOWED

USE OF ALCOHOL:  NEVER  SOCIAL  NO LONGER USE  HISTORY OF ALCOHOL ABUSE

USE OF TOBACCO:  NEVER  QUIT – HOW LONG AGO? \_\_\_\_\_ CURRENT  PACKS/DAY FOR \_\_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT – HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_

6. **PODIATRIC HISTORY:**

Describe your condition or injury: \_\_\_\_\_

Which foot is affected?:  Right  Left  Both How long have you had this condition: \_\_\_\_\_

Describe the pain (Mild, Moderate, Severe, Throbbing, Sharp, Shooting, Dull Ache, Burning, Etc): \_\_\_\_\_

When does it hurt? (First thing in the morning, All the time, Occasional/Intermittent, Only when standing, walking or running, After running, With weather changes, Etc) \_\_\_\_\_

Describe any measures or previous treatment and their results (self treatment with pads, over the counter remedies, soaks or visits to family physicians or other specialists) \_\_\_\_\_

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_