Patient Name:

MEDICAL INFORMATION

This information is important for our records and your health.

Describe your foot problem_____
_____
_____
_____

How long has this been bothering you? _____Days_____Weeks_____Years

Any past problems of your feet and ankles?_____
_____
_____

Any past surgical procedures on your feet and ankles? _____
_____
_____

Shoe Size _____Current Weight _____ Height _____

ARE YOU ALLERGIC OR SENSITIVE TO:

Antibiotics (Penicillin, Sulfa, etc.)? _____
Any Medicines _____
Tape? _____ Betadine (Iodine)? _____Other_____
Have you had any problems taking aspirin or ibuprofen (Advil, Motrin)? Yes___ No ___
Any problems with local anesthetics (Novacaine, Lidocaine)? Yes_____ No _____

GENERAL HEALTH INFORMATION:

Do you have Diabetes? Yes_____No ____ If yes, do you take insulin? Yes____ No ____
Number of years _____
Have you had any serious illness? _____
Have you had any major surgeries? _____
Are you under a physician's care? Yes _____ No _____ If yes, for what condition?_____
_____
Family Physician _____ Date you last saw this Doctor? _____
May we contact you physician about your health? Yes_No_Physician's tel #_____
Name of your Pharmacy or Drug Store? _____ Phone # _____
What medications do you take regularly?_____