PATIENT HISTORY

PATIENT'S NAME: ________________________________ DATE OF BIRTH: ________

WHAT IS THE REASON FOR YOUR VISIT?_____________________________________

HAVE YOU HAD PREVIOUS FOOT CARE? YES NO BY WHOM: ________________

PLEASE ANSWER ALL OF THE QUESTIONS BELOW

1. HOW IS YOUR GENERAL HEALTH? EXCELLENT GOOD POOR
2. PRIMARY CARE OR REFERRING PHYSICIAN'S NAME AND ADDRESS____________

____

3. PLEASE CHECK APPROPRIATE PLACES. I HAVE OR HAVE HAD THE FOLLOWING:

_____DIABETES	_____STROKE	_____LEG CRAMPS	_____TUMORS
_____BLEEDING PROBLEMS	___EPILEPSY	_____ASTHMA	_____GOUT
_____HIGH BLOOD PRESSURE	_____STOMACH ULCER	_____TUBERCULOSIS	_____POLIO
_____KIDNEY TROUBLE	_____HEART TROUBLE	_____ARTHRITIS	_____ANEMIA
_____VARICOSE VEINS	_____CIRCULATION	_____GLAUCOMA	_____CANCER
_____FAINTING SPELLS			

4. OTHER PREVIOUS ILLNESSES:____
5. PREVIOUS OPERATIONS OR HOSPITALIZATIONS:____
6. PREVIOUS INJURIES:____
7. WHAT MEDICATIONS ARE YOU TAKING? (include prescription, over-the-counter, and herbal supplements)____
8. ARE YOU TAKING BIRTH CONTROL PILLS? YES NO
9. (_____) I AM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE

   (_____) I AM ALLERGIC TO (PLEASE CHECK):

_____ASPIRIN	_____MERCURIALS	_____NYLON PLASTIC	OTHER
_____NOVOCAIN	_____MERTHIOLATE	_____ANTIHISTAMINES	____________
_____CODEINE	_____IODIINE	_____PENCILLIN	____________
_____DEMEROL	_____ADHESIVE	_____SULFA	____________

10. TYPES OF SHOES AND SIZE WORN: ____

11. FAMILY MEDICAL PROBLEMS: ____

12. IN CASE OF EMERGENCY, WHOM COULD WE NOTIFY?

NAME ________________________ ADDRESS __________________________________

PHONE NUMBER _________________ RELATIONSHIP _________________________

HOW DID YOU HEAR ABOUT US?

- Physician referral
- Family member or friend
- Internet
- Advertisement -- where? ____________________________
- Other: ____