

HEALTH HISTORY

Name: _____ DOB: _____

Fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform our office when there are any changes in the medical information you provide.

Please describe your current foot problem: _____

Was the problem a result of an accident or event (explain)? _____

Date Problem Began: _____ Have you visited a doctor for the problem: YES or NO

Previous X-rays for condition? YES or NO Previous Treatment for condition? _____

Height: _____ Weight: _____ Blood Pressure: _____

Shoe Size: _____ How much of your day is spent on your feet? 25% 50% 75% 90% 100%

List any sports you participate in: _____

Please circle any of the following you have or have been treated for: (circle)

Arch pain	Heel Pain/Spurs	Leg Pain	Hammertoe	Neuroma	Ingrown Toenails	Intoeing	Bunions
Rash	Corns/Calluses	Warts	High Arches	Flat Feet	Foot or Ankle Break/Sprain		

Please indicate any personal history below: (circle yes or no)

General

Diabetes	No	Yes
Arthritis	No	Yes
Hepatitis	No	Yes
HIV	No	Yes
Circulatory Problems	No	Yes
Respiratory Problems	No	Yes
Gastrointestinal Problems	No	Yes

Neurological

Numbness/tingling	No	Yes
Paralysis	No	Yes
Headaches	No	Yes
Light Headed/Dizzy	No	Yes
Convulsions/Seizures	No	Yes
Tremors	No	Yes
Head Injury	No	Yes

Hematologic/Lymphatic

Anemia	No	Yes
Phlebitis	No	Yes
Blood Disease	No	Yes
Bleeding/Bruising	No	Yes
Slow to heal after cut	No	Yes
Past transfusion	No	Yes
Enlarged Glands	No	Yes

Musculoskeletal

Joint Pain	No	Yes
Joint Stiffness/Swelling	No	Yes
Muscle Pain/Cramps	No	Yes
Weakness/Pain/Cramps	No	Yes
Back Pain	No	Yes
Cold Extremities	No	Yes
Difficulty Walking	No	Yes

Cardiovascular

Heart Trouble	No	Yes
Chest Pain	No	Yes
Palpitation	No	Yes
Shortness of Breath	No	Yes
Swelling of hand/feet	No	Yes
High Blood Pressure	No	Yes

Psychiatric

Memory Loss/Confusion	No	Yes
Depression	No	Yes
Nervousness	No	Yes
Insomnia	No	Yes

Use of Alcohol: (circle) never rarely moderate daily previously currently ___ drinks a day

Use of Tobacco: (circle) never rarely moderate daily previously currently ___ packs a day

Previous Hospitalizations: _____

Family Medical History:

age

medical disease/foot problems

if deceased, cause of death

Father: _____

Mother: _____

Siblings: _____

Children: _____