

# History

Name: \_\_\_\_\_

Describe your current foot problem: \_\_\_\_\_ How Long? \_\_\_\_\_

Describe onset: \_\_\_\_\_ Previous Treatments: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Year of last Exam: \_\_\_\_\_

Specialists: \_\_\_\_\_ Occupation: \_\_\_\_\_

Athletic Activities: \_\_\_\_\_

**Family History:** ( ) Diabetes ( ) High Blood Pressure  
( ) Heart Disease ( ) Bleeding Tendencies

**Social History:** ( ) Smoking ( ) Alcohol  
( ) Recreational Drugs; How Much? \_\_\_\_\_  
How Long? \_\_\_\_\_

**Allergies:** ( ) NONE ( ) Penicillin ( ) Aspirin ( ) Codeine ( ) Iodine ( ) Novocain ( ) Demerol  
( ) Sulfa ( ) Local Anesthetics ( ) Shell Fish ( ) Latex ( ) Tape Other: \_\_\_\_\_

Do you take blood thinners? ( ) Yes ( ) No

List all medications you are currently taking (please include Aspirin, Tylenol, Vitamins and Birth Control Pills). If you are not currently taking any medications, please write NONE or N/A on line one.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Are you currently taking any of the following: ( ) NONE ( ) Echinacea ( ) Garlic ( ) Ginger  
( ) Gingko Biloba ( ) St. John's Wort ( ) Ginseng ( ) Kava kava ( ) Feverfew ( ) Ephedra

**COMPLETE BOTH SIDES**

**MAJOR DISEASE:** ( ) NONE ( ) Diabetes / how long? \_\_\_\_\_  
( ) Hypertension ( ) Angina ( ) Heart Disease ( ) Heart Attack  
( ) Arrhythmia ( ) Murmur ( ) Mitral Valve Prolapse ( ) Stroke ( ) Chest Pain

**HEENT:** ( ) NONE ( ) Headache ( ) Eye Problems ( ) Glasses ( ) Hearing Problems ( ) Hearing Aide

**RESPERATORY:** ( ) NONE ( ) Asthma ( ) Bronchitis ( ) Frequent Colds ( ) Lung Disease  
( ) Shortness of Breath ( ) Tuberculosis ( ) Emphysema

**ARTHRITIS:** ( ) NONE ( ) Osteoarthritis ( ) Rheumatoid ( ) Gout ( ) Sero-negative: Reiter's, PsA,  
Anklyosing Spondylitis, CCPD, Irritable Bowel

**VASCULAR:** ( ) NONE ( ) Anemia ( ) Sickle Cell ( ) Bleeding Disorders ( ) Poor Circulation  
( ) Night Cramps ( ) Leg Pain When Walking ( ) Vein Problems ( ) Spider Veins  
( ) Varicose Veins ( ) Swelling ( ) Phlebitis  
( ) Leg Ulcerations ( ) Blood Clots ( ) Transfusions

**PSYCHOLOGICAL:** ( ) NONE ( ) Anxiety ( ) Depression ( ) Psychiatric Conditions  
( ) Drug Dependence ( ) Alcohol Dependence  
( ) OTHER ILLNESSES: \_\_\_\_\_

**GASTROINTESTINAL:** ( ) NONE ( ) Ulcers ( ) Stomach Problems ( ) Hiatal Hernia  
( ) Bowel Disorders ( ) GI or Rectal Bleeding ( ) Acid Reflux-GERD

**MISCELLANEOUS:** ( ) NONE ( ) Epilepsy ( ) Thyroid Disease ( ) Muscle Disease  
( ) Kidney Disease ( ) Bladder Problems ( ) Venereal Disease  
( ) Skin Conditions ( ) Cancer History ( ) Hepatitis

Previous Surgeries & Hospitalizations: ( ) NONE

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Authorization**

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status or medications, I will inform the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_