INITIAL PATIENT HISTORY

HAVE YOU HAD OR BEEN TREATED FOR:

❑ **No Previous Foot or Ankle Problems**

- ❑ Corns or Calluses
- ❑ Warts
- ❑ Athlete's Foot
- ❑ Fungal Toenails
- ❑ Ingrown Nails
- ❑ Heel Pain
- ❑ Arch Pain
- ❑ Flat Feet
- ❑ High Arch Feet
- ❑ Custom Orthotics
- ❑ Problems Walking
- ❑ In-Toeing
- ❑ Out-Toeing
- ❑ Toe Walking
- ❑ Childhood Foot Problems
- ❑ Bunions
- ❑ Hammer Toes
- ❑ Neuroma
- ❑ Sciatica
- ❑ Amputation
- ❑ Foot Numbness
- ❑ Back Pain
- ❑ Foot or Leg Ulcers
- ❑ Broken Bones Foot/Ankle
- ❑ Ankle Sprain
- ❑ Knee Pain
- ❑ Cramps in Legs/Feet
- ❑ Varicose Veins
- ❑ Gout

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Anxiety Disorder
- ❑ Bleeding Problems
- ❑ Blindness
- ❑ Blood Clot
- ❑ Cancer
- ❑ Claustrophobia
- ❑ Cyst/Skin Growth
- ❑ Diabetes
- ❑ Dialysis
- ❑ Depression
- ❑ Epilepsy (Seizures)
- ❑ Fibromyalgia
- ❑ German Measles (Rubella)
- ❑ Glaucoma
- ❑ Has Pacemaker
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV or AIDS
- ❑ Keloid/Thick Scars
- ❑ Kidney Stones/Disease
- ❑ Liver Disease or Hepatitis
- ❑ Lung Disease
- ❑ Lyme's Disease
- ❑ Mononucleosis
- ❑ Nerve Disorder
- ❑ Osteoporosis
- ❑ Poor Circulation
- ❑ Polio
- ❑ Psoriasis
- ❑ Psychiatric Disorders
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Skin Problems
- ❑ Stomach Reflux/Ulcer
- ❑ Stroke
- ❑ Swelling
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other Illness: _____
- ❑ Have you had any surgery? _____
- ❑ Organ Transplant
- ❑ Vascular Grafts
- ❑ Joint Implants
- ❑ Replacement Heart Valves
- ❑ Chemotherapy

ARE YOU ALLERGIC TO:

❑ No Known Allergies

	List Reaction		List Reaction		List Reaction
❑ Penicillin		❑ Sulfa		❑ Any Kind of Food	
❑ Tetracycline		❑ Tylenol		❑ Any Metal/Jewelry	
❑ Aspirin		❑ Iodine		❑ Local Anesthetic	
❑ Codeine		❑ Latex		❑ Other Allergies	

FAMILY HISTORY:

Have your grandparents, parents, brothers or sisters ever had:

	Family Member		Family Member		Family Member
❑ Cancer		❑ High Blood Pressure		❑ High Cholesterol	
❑ Diabetes		❑ Sickle Cell Disease		❑ Arthritis	
❑ Heart Attack		❑ Stroke/Blood Clots		❑ Others	

SOCIAL HISTORY:

❑ Smoke/Use Tobacco	Circle one	Never		Occasionally		Daily	Quit
❑ Drink Alcohol	Circle one	Never	Socially	Daily	Excessive	Quit	
❑ Recreational Drugs	Circle one	Never	Socially	Daily	Excessive	Quit	
❑ % of the day on your feet	Circle one	<25%	25%	50%	75%	>75%	

Shoe Size _____

Shoe Type _____

DO YOU TAKE ANY MEDICATIONS?

Please list them _____

Are you pregnant? NO ❑ YES ❑ *Are you Breastfeeding?* NO ❑ YES ❑

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____