





**MEDICAL INFORMATION**

Height: \_\_\_\_\_ ' \_\_\_\_\_ " Weight: \_\_\_\_\_ lbs

**ALLERGIES** (CIRCLE)

None    Penicillin    Sulfa Drugs    Codeine    Aspirin    Tape    Latex    Iodine/Shellfish

Other Allergies: \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY** (CIRCLE)

Do you smoke?    No    Yes    \_\_\_\_\_ pk/day x \_\_\_\_\_ years.    Quit, but I smoked \_\_\_\_\_ pk/day x \_\_\_\_\_ years.

Drink Alcohol?    No    Yes    if yes, how often \_\_\_\_\_

Recreational Drugs?    No    Yes    if yes, how often \_\_\_\_\_

**MEDICAL HISTORY**

Diabetes	Yes	No	Asthma	Yes	No	Gout	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Psoriasis	Yes	No
Heart Disease	Yes	No	Liver Disease	Yes	No	Back Problems	Yes	No
Bleeding Problems	Yes	No	Eye Disease	Yes	No	Stomach Ulcers	Yes	No
Circulation Problems	Yes	No	Urinary Tract Problem	Yes	No	Rheumatoid Arthritis	Yes	No
Lung Disease	Yes	No	Convulsions	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Skin Tumors	Yes	No	Currently Pregnant?	Yes	No

If yes to any of the above, please give details: \_\_\_\_\_  
 \_\_\_\_\_

Previous Surgery & Other Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_

**WHERE IS YOUR FOOT/ANKLE PROBLEM?**

Which Foot?    Right    -    Left    -    Both Feet

Duration of Problem: \_\_\_\_\_ day(s) - week(s) - month(s) - year(s)

When does it hurt?    First Steps in Morning - End of Day - Standing - Walking - Running - At Rest

(CIRCLE)

Other: \_\_\_\_\_

Any previous treatment? \_\_\_\_\_

Any previous foot surgery of any kind for this problem or other problems? \_\_\_\_\_  
 \_\_\_\_\_