5 MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	__	__	Diabetes	__	__	Psychiatric Care	__	__
Allergies to Anesthetics	__	__	Ear Problems	__	__	Radiation Treatment	__	__
Allergies to Medicine			Epilepsy	__	__	Rash	__	__
or Drugs	__	__	Eye Problems	__	__	Respiratory Disease	__	__
Anemia	__	__	Fainting	__	__	Rheumatic Fever	__	__
Angina	__	__	Foot or Leg Cramps	__	__	Shortness of Breath	__	__
Arthritis	__	__	Gout	__	__	Sinus Problems	__	__
Artificial Heart Valves			Headaches	__	__	Special Diet	__	__
or Joints	__	__	Heart Disease	__	__	Stroke	__	__
Asthma	__	__	Hemophilia	__	__	Swelling in Ankles, Feet	__	__
Back Problems	__	__	Hepatitis or Jaundice	__	__	Swollen Neck Glands	__	__
Bleeding Disorders	__	__	High Blood Pressure	__	__	Tired Feet	__	__
Cancer	__	__	Kidney Problems	__	__	Tuberculosis	__	__
Chemical Dependency	__	__	Liver Disease	__	__	Ulcers	__	__
Chest Pain	__	__	Low Blood Pressure	__	__	Varicose Veins	__	__
Chronic Diarrhea	__	__	Nervous Problems	__	__	Venereal Disease	__	__
Circulatory Problems	__	__	Phlebitis	__	__	Weight Loss, unexplained	__	__

Surgeries you have ____
____
____

Hospitalization other than for the surgeries listed____
____

Family physician ____Last visit date______________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ______ Yes _____ No

If yes, please explain____
____
____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins. ________________
____
____
Pharmacy Name(s)____
Pharmacy Phone(s) ____
Do you take oral contraceptives? ____ Yes ____ No

7 ALLERGIES

__ Adhesive/Tape
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__ Iodine
__ Local
__ Novocaine
__ Penicillin
__ Seafoods
__ Sulfa
Other______________________________

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature____ Date________________________