

Please list any medications you are currently taking, either prescription or over the counter:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: Is there any history of any skin reaction or sickness due to an injection, oral, or topical administration of:

Penicillin.....Y / N  
 Morphine.....Y / N  
 Codeine.....Y / N  
 Demerol.....Y / N  
 Novocain.....Y / N  
 Aspirin.....Y / N  
 Empirin, Tylenol (*if yes, circle*).....Y / N  
 Advil, Aleve, or Motrin (*if yes, circle*).....Y / N  
 Sulfa drugs.....Y / N  
 Adhesive tape.....Y / N  
 Latex.....Y / N  
 Shrimp, Iodine, or Merthiolate.....Y / N  
 Other \_\_\_\_\_

Did you previously or do you now wear:

Shoe Inserts? Y / N      Still using them? Y / N  
 Do or did they help? Y / N

Orthotics? Y / N      Still using them? Y / N  
 Do or did they help? Y / N

The orthotics were obtained from:

\_\_\_\_ Another Podiatrist      \_\_\_\_ An orthopedist  
 \_\_\_\_ A Physical Therapist      \_\_\_\_ A Chiropractor  
 \_\_\_\_ Other: \_\_\_\_\_

Percent of hours spent on your feet

20%      40%      60%      80%      100%

List your activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have, or have you ever been treated for:

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> A heart Condition
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Headaches
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Gout	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Lyme's Disease
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hearing/Ear Disorder
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Keloid/Thick Scar	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nerve Disorder	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> NONE of these
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stomach Ulcer	

**Others:** \_\_\_\_\_

Have you had/been treated for:

<input type="checkbox"/> Corns/Calluses	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Heel Pain
<input type="checkbox"/> Leg/Foot Ulcers	<input type="checkbox"/> Arch Pain	<input type="checkbox"/> Toe Walking
<input type="checkbox"/> Broken Foot or Ankle Bones	<input type="checkbox"/> Bunions	<input type="checkbox"/> NONE of these
<input type="checkbox"/> Hammer/Mallet toes	<input type="checkbox"/> In-toeing	
<input type="checkbox"/> Let/Foot Cramps	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Athletes Foot	
<input type="checkbox"/> Gait (walking) problems	<input type="checkbox"/> Ingrown nails	
<input type="checkbox"/> Childhood Foot problems	<input type="checkbox"/> Foot Numbness	
<input type="checkbox"/> Warts	<input type="checkbox"/> Ankle Sprain	
<input type="checkbox"/> Fungal Nails	<input type="checkbox"/> Flat Feet	
<input type="checkbox"/> Neuroma	<input type="checkbox"/> High Arched Feet	

List relationship to family members who have had:

Diabetes: \_\_\_\_\_  
 Arthritis: \_\_\_\_\_  
 Stroke: \_\_\_\_\_  
 Cancer: \_\_\_\_\_  
 Foot Problems: \_\_\_\_\_  
 Heart Attack: \_\_\_\_\_  
 High Blood Pressure: \_\_\_\_\_  
 \_\_\_\_\_  
 Birth Defects: \_\_\_\_\_