Medical History

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

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

Family History____
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Advanced Directive: Do you have a Living Will? Yes_____No______

Do you have any of the following? Poor Vision____ Language Barrier____

Poor Hearing_____

Religious Cultural Barrier____

None of the above____

Reason for consultation____
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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.

Signature______________________________ ______________________Date___________________________