COMPREHENSIVE MEDICAL HISTORY

This information is important for our records and your health

Describe your foot problem: ____

____

____

ALLERGIES: Is there a history of sensitivity or sickness with: *(Circle all the apply)* *** ***No known drug allergies***

Penicillin Sulfa Erythromycin Epinephrine Morphine Codeine Demerol Novocain Aspirin Tylenol

Advil Aleve Motrin NSAIDs Tape Iodine / Betadine Latex Adhesives Fabrics

Others not listed: ____

PAST MEDICAL HISTORY: Have had or been diagnosed with ***even as a child*** Circle all that apply **(NONE)**

AIDS / HIV	Diabetes	Kidney Disease	Pneumonia
Alzheimer's Disease	Epilepsy	Liver Disease	Polio
Anemia	Fibromyalgia	Lung Disease	Psychiatric Disorder
Angina	Gout	Measles	Restless leg Syndrome
Arthritis	Headaches	Mumps	Sciatica
Asthma	Heart Attack	Nervous Disorder	Stroke
Bowel Disease	Hemophilia	Osteoporosis	Thyroid Disease
Cancer-type: ___________	Hepatitis	Peripheral Neuropathy	Tuberculosis
Chicken Pox	Hypertension	Phlebitis	Vascular Disease

Other: ____

* Have you received the Influenza Vaccination? Yes / No : If yes when:_____________

*Have you received the Pneumonia Vaccination? Yes / No

*Are you under active Chemotherapy for any reason? Yes / No *Are you treated with Kidney Dialysis? Yes / No

Shoes Size: ___________

CURRENT MEDICATIONS:

Is Medication list Attached?: Yes / **Don't take any medications

Medication name / Dose / Frequency & Administration route

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

PLEASE TURN OVER

NAME: ______________________________ ACCT. #: ____________ DATE: _____________ ENTERED BY:______