

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: _____