

MEDICAL INFORMATION

This Information is Important For Our Records and Your Health Date: _____

Describe your foot problem [right, left, both] _____

Have you tried anything to treat the problem? _____

How long has it been bothering you? Days _____ Weeks _____ Months _____ Years _____

Please indicate which foot problems you now have or have had in the past:

- | | | | |
|---|---|---|-------------|
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Bunions | other _____ |
| <input type="checkbox"/> Corns and Calluses | <input type="checkbox"/> Numbness in Feet or Legs | <input type="checkbox"/> Flat Feet | |
| <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Ingrown Toenails | |
| <input type="checkbox"/> Plantar Warts | <input type="checkbox"/> Swelling in Ankles or Feet | <input type="checkbox"/> Tired Feet | |

Height _____ Current Weight _____ Shoe Size _____

3 ALLERGIES

Are you allergic to or sensitive to:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Adhesive/Tape | <input type="checkbox"/> Anesthetics |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Novocain |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Others _____ |

4 MEDICATIONS

What medications do you take regularly?

Please include prescriptions, over-the-counter medications, and vitamins.

Name of Pharmacy or Drug Store:

Phone # _____

5 GENERAL HEALTH INFORMATION

Do you have **diabetes**? Yes No If yes, do you take insulin? Yes No Number of years that you've had diabetes _____

Please list any surgeries you have had _____

Hospitalizations other than for the surgeries listed _____

Are you under a physician's care? Yes No If yes, for what condition? _____

Physician _____ Date you last saw this Doctor _____

May we contact your physician about your health? Yes No Physician's Phone Number _____

Do you smoke? Yes No Number of packs per day _____ How many years have you smoked? _____

Did you previously smoke? Yes No Number of years ____ Do you have a Heart Valve Implant or Murmur? Yes No

Do you drink alcohol or beer? Yes No If yes, how much? Less than 1-2 per week 1-2 per day More than 2 per day

Do you drink caffeinated beverages? Yes No Number of cups/cans per day _____

Employment: Sit at job _____ Stand at job _____ Stand & walk at job _____ Retired _____ Homemaker _____

Athletic activities in which you participate. (please list and indicate frequency) _____

Anything else you want to tell the doctor? _____

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6 MEDICAL HISTORY

Please check which best describes your general health: Excellent Good Fair Poor

Please check any of the following you have, or have had a problem with in the past:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nose Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Respiratory Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Infection | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Slow or non-healing wounds |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Swelling of the feet/ankles |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Unexplained fever / weight loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Venereal Disease |

Do you have any artificial joints? Hip Yes No Right / Left Knee Yes No Right / Left Other _____

Women Only: Are you pregnant? Yes No Breastfeeding? Yes No Taking Oral Contraceptives? Yes No

7 INDICATIONS FOR NAIL CARE TREATMENT

(Please circle all symptoms & history)

Diabetic (IDDM, NIDDM), Peripheral Vascular Disease, Peripheral Neuropathy, decreased or absent hair growth,

Pigment change/skin discoloration, dependent rubor, thin or shiny skin cold feet edema tingling burning

Thick Nails Limitation of walking due to painful nails

8 FAMILY HISTORY

MOTHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
FATHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
BROTHER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____
SISTER	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of Death _____

Is there a family (blood relative) history of any of the following medical problems:

- | | | | |
|---|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Circulation problems of the legs / feet | |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Flatfeet | |

9 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 examine, administer and after consultation, perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet. I have also received and read a copy of HIPPA Privacy Act and understand my rights.

___ Initial for Permission to leave information pertaining to medical care on voicemail. ___ Initial not to leave information on voicemail

Signature

Date