MEDICAL HISTORY

PATIENT NAME	BIRTH DATE / /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS

❑ Penicillin	❑ Sulfa	❑ Local Anesthetic	❑ Anti-inflammatory Medication
❑ Codine	❑ Tape	❑ Nausea From Anesthetic	❑ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	HOW LONG?	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

❑ Surgery	❑ Orthotics	❑ Oral Medications	❑ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name	Phone Number ( )		
Street Address	City	State	Zip Code

Have You Ever Been Put To Sleep For Surgery? Yes ☐ No ☐

SHOE SIZE	HEIGHT	WEIGHT
DO YOU DRINK?	❑ NO ❑ YES	DRINKS PER WEEK
DO YOU SMOKE?	❑ NO ❑ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Artificial Joints (hip, knee, etc.)	❑ Yes	❑ No	H.I.V. Positive	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Kidney Trouble	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
fibromyalgia	❑ Yes	❑ No	Motion Sickness	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Neurological Disorder	❑ Yes	❑ No
Heart (Surgery, Disease, Attack)	❑ Yes	❑ No	Psychiatric/Psychological Care	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Stomach Problems / Reflux / Heartburn	❑ Yes	❑ No
Hepatitis A(Infectious B (serum)	❑ Yes	❑ No	Ulcers (Diabetic)	❑ Yes	❑ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all Questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X

Patient/Guardian Signature Date

HISTORY REVIEWED BY: DR. SIGNATURE DATE