PATIENT MEDICAL HISTORY

Name:_____ Soc. Sec#_____ DOB_____ Age_____

Mailing Address_____ City_____ State/ Zip_____

Marital Status_____ Home # _____ Work # _____ Cell # _____

Place of Employment /Years employed *_____

Emergency Contact: _____ PH# _____ Shoe Size_____ Ht.____Wt.____

Pharmacy*_____ If a minor, patient list parent/guardians' names _____

Language Preference_____ Race_____ Ethnicity_____

Email address:* _____

How do you prefer to be contacted? (please circle) via phone via email (please list)

Do you have or have you ever been treated for:*

__Anemia	__Diabetes	__Hepatitis	__Nerve disorder
__Ankle Injury	__Epilepsy	__High arched feet	__Neuroma
__Arch pain	__Fibromyalgia	__HIV	__Phlebitis
__Asthma	__Flat feet	__Hypertension	__Psychiatric disorder
__Athlete's foot	__Fungal toenails	__Ingrown nails	__Rheumatic arthritis
__Back pain	__Glaucoma	__Kidney disease	__Rheumatic fever
__Broken foot bones	__Gout	__Knee pain	__Stomach ulcer
__Bunions	__Hammertoes	__Liver disease	__Stroke
__Cancer	__Heart attack	__Lung disease	__Trauma
__Child foot problems	__Heart disease	__Lupus	__None of the above
__Depression	__Heel pain	__Multiple Sclerosis	

List any Surgeries and the date performed:* _____
_____

List Medications you are currently taking:*_____
_____
_____

List any allergies to medications:* _____

Do you smoke now?* Y or N

Are you a former smoker?* Y or N If yes, Start date _____ End date _____

Alcoholic Beverages: None__Rarely__ Moderately__ Daily___

Please turn over and complete back side of form

Family history* (specify family member):

i.e. M=mom, D=dad

__Arthritis __Foot problems

__Birth Defect __Heart attack

__Cancer __Hypertension

__Diabetes __Stroke

What is your foot complaint today?_____

_____

Foot complaints present how long?_____

Describe the pain __Sharp__ Dull__ Shooting

__Aching__ Burning__ Tingling__ Throbbing

Primary care physician_____ **Date last seen___/___/_____**

Were you referred to our office? Y N **If yes, who referred you?_____**

***Required fields**