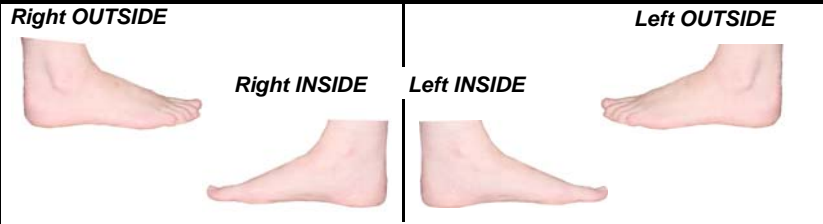




DATE: _____

NAME: _____

DATE OF BIRTH: _____



Right BOTTOM Right TOP Left TOP Left BOTTOM



- Please mark the location of your problem's on the "above" diagrams with an "X"
- When did your problem start? _____
- Describe your foot problem and the cause, if you know: _____
- Circle all that applies to your pain: burning shooting sharp aching throbbing numbness tingling dull
- What makes the problem worse? _____
- List previous medical treatments or home remedies: _____
- Anything else we should know: _____

SHOE SIZE: _____ **Height:** _____ **Weight:** _____

ARE YOU DIABETIC: (check) **Yes** **No**

If **YES**, how long have you been diagnosed? _____

Past Medical History: (check if applicable)

<input type="checkbox"/> DIABETES	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Gout	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Circulation	<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Kidney	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Other _____		

Surgical History:

Do you have Artificial Joints? _____

Have you had any Anesthesia Complications? _____

Explain: _____

Family History (check if applicable)

<input type="checkbox"/> Is there a Family History of any of these disorders?	<input type="radio"/> Tuberculosis	<input type="radio"/> Heart Attack	<input type="radio"/> Cancer	<input type="radio"/> Other _____
	<input type="radio"/> Epilepsy	<input type="radio"/> Kidney Disease	<input type="radio"/> Spinal Disorder	_____
	<input type="radio"/> Gout	<input type="radio"/> Diabetes	<input type="radio"/> Mental Illness	_____
	<input type="radio"/> Hypertension	<input type="radio"/> Allergies	<input type="radio"/> Arthritis	_____
	<input type="radio"/> Alcoholism	<input type="radio"/> Migraines		_____

Social History (check if applicable)

<input type="checkbox"/> Marital Status/Living Arrangement	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Other
<input type="checkbox"/> Use of Tobacco/Alcohol/Drugs	<input type="radio"/> Tobacco	<input type="radio"/> Alcohol	<input type="radio"/> Drugs
<input type="checkbox"/> Current Employment/Occupation: _____			
<input type="checkbox"/> Level of Education	<input type="radio"/> Years of School _____	<input type="radio"/> Degrees _____	

Current Medications: (please list ALL medications below or ATTACH a list of you medications):

<input type="checkbox"/> ALLERGIES (if applicable)	<input type="radio"/> Penicillin	<input type="radio"/> Morphine/ Demerol _____	<input type="radio"/> Adhesive Tapes _____
	<input type="radio"/> Sulfa Drugs	<input type="radio"/> Antibiotics _____	<input type="radio"/> Any Foods _____
	<input type="radio"/> Aspirin	<input type="radio"/> Other Drugs _____	<input type="radio"/> Any Chemicals _____
	<input type="radio"/> Codeine	<input type="radio"/> Other Forms of Allergies _____	

What kind of allergic reactions do you have to these medications? _____