

Medical History

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Shoe size: _____ Do you have Diabetes? Y N

Primary Physician: _____ Referring Physician: _____

Pharmacy & Location: _____

Do we have permission to access your medication history from your pharmacy? Y N

(If you do not allow access, you must provide a list of all medications you are currently taking.)

What type of foot/ankle problem are you having? _____

Do you exercise or participate in any types of sport activities, what type? _____

Social History:

Do you smoke? Yes No If yes, number of packs per day is _____ If yes, how long have you been a smoker? _____	If not a current smoker, have you ever been a smoker? Yes No If yes, how long ago did you quit? _____	Do you use alcohol? Yes No If yes, how often? Rarely Often Socially
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Medical History: (please check all that apply)

Arthritis	Cancer	Gout	Heart Attack	Hepatitis
High Cholesterol	HIV/Aids	Injury/Fracture	Osteoporosis	Stroke
Rheumatoid Arthritis	Diabetes 1 or 2	Ulcers	High Blood Pressure	Kidney Disease
Thyroid Disease	Psoriasis	Other	Other	Other

Surgical History:

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Allergies:

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PATIENT/PARENT SIGNATURE

DATE