MEDICAL HISTORY

Your Name: _____ _____ _____
(Last) *(First)* *(M.I.)*

Height _____ *Weight*_____

Family Physician: _____ *Phone:* _____

Physician's Address: _____*City:*_____*State:*_____

Specialist _____**For what condition?**_____

Are you currently working? YES NO Retired Employer_____ **Type of job**_____

What type of foot/ankle problem are you having?_____**(use back of page if necessary)**

Have you ever been diagnosed with: (please circle) In blank please specify type where indicated

Anemia	**Degenerative arthritis**	**HIV**	**Rheumatic fever**
Asthma	**Diabetes**	**Hypothyroid**	**Rheumatoid arthritis**
Autoimmune dz_____	**Emphysema (COPD)**	**Jaundice**	**Scoliosis**
Bladder Probs_____	**Fibromyalgia**	**Joint Replacement Surg**	**Seizure (most recent)**
Brain/nervous dz_____	**Gout**	**Kidney Prob_____**	**Stomach Prob_____**
Breathing Prob_____	**Heart Attack**	**Liver dz_____**	**Stroke**
Cancer (type_____)	**Heart Probs/Chest Pain**	**Low Blood Sugar**	***NONE OF THE ABOVE***
Circulation problems	**Hepatitis**	**Lung Dz_____**	
Coronary artery disease	**High Blood Pressure**	**Osteoporosis**	

Have you ever had an addiction to drugs or alcohol? YES NO ***(provide specifics on back)***
Have you ever been a patient in a pain treatment program ? YES NO ***(provide specifics on back)***

Do you smoke? YES NO If no, have you ever smoked? YES NO
If yes, how much per day? Estimated____packs per day for _____ years Quit _____(year)

Do you have a chronic cough? YES NO

Are you a menstruating female? YES NO
Are you currently nursing? YES NO
Is there any possibility that you may be pregnant? YES NO

Are you a Diabetic? YES NO If yes, for how long?_____
If yes, are you or have you ever been on insulin? YES NO If yes, for how long? _____
Do you currently receive Homehealth Care or Skilled Nursing YES NO Facility Name_____
Please list the most recent glucose level and the date it was taken: _____
Please list the range of your average glucose level: _____
Are you currently taking aspirin, coumadin, plavix or ticlid? YES NO
Do you have any allergies to iodine or shellfish? YES NO
Please list all medications that you are currently taking. ***(use back of page if necessary)***

_____

_____

Please describe any allergic reactions you have to ANY medication._____

Have you ever been or are you currently disabled? YES NO
If yes, For what condition (be specific)?_____
How long have you been disabled?_____

Please list family medical history (mother, father, brothers, sisters, aunts, uncles, grandparents) on back of page (diabetes, heart disease, high blood pressure, cancer, arthritis, depression, liver disease, gout, CMT, etc, etc)