

Welcome to our office! Please complete the health information below.
 This information helps us to safely and better care for your needs.



Your Name: _____ Age: _____
 Date of Birth: / /

Reason for your visit: _____ Primary Care Physician: _____ Last seen: _____
 Referring Physician: _____

Past Medical History	Yes	No	Other past medical history not otherwise listed:			
Amputation						
Anaphylactic reaction						
Anesthesia reaction						
Anxiety disorder			MEDICATIONS (including aspirin, birth control pills, over the counter medications and supplements, both vitamin and herbal)			
Arthritis						
Asthma						
Back pain						
Birth control pill use						
Blood clot history						
Blood clotting abnormalities						
Cancer						
Chemical addiction						
Circulation problems						
Congestive heart failure						
COPD/emphysema						
Depression			Allergies (please check)	Yes	No	If yes, reaction
Diabetes (if yes, answer below)			Tape/Adhesives			
Average blood sugar:			Eggs			
Last A₁C:			Iodine			
Fibromyalgia			Latex			
Gout			Nickel/metal/jewelry			
Heart Disease			NSAIDS/anti-inflammatories			
Heart valve condition/replacement			Penicillin			
High cholesterol			Shellfish			
HIV/AIDS			Sulfa drugs			
High blood pressure			X-ray dye			
Hyperthyroidism / Hypothyroidism			Others:			
Irritable / Inflammatory bowel						
Kidney disease / impaired function						
Large scars/keloids						
Liver condition						
Melanoma						
Menopause						
Mitral valve prolapse						
Neurological problems/diseases			Previous hospitalizations and surgeries: (note year and any complications)			
Neuropathy						
Osteopenia / Osteoporosis						
Pacemaker						
Psoriasis						
Pulmonary embolism						
Reflux/heartburn						
Seizure disorder						
Skin ulcers						
Sleep apnea / CPAP			Current weight:	Height:	Shoe size:	
Stomach ulcers			Other treating physicians:			
Stroke						
Tuberculosis						

Family history If yes, please check which family member	Mother	Father	Sibling	Child	Other family (specify)
Alcoholism					
Amputation					
Anesthesia problems					
Arthritis					
Bleeding disorders					
Bunions/foot deformity					
Cancer					
Blood clots					
Diabetes					
Heart disease					
Heart problems					
Kidney disease					
Liver problem					
Lupus/autoimmune disease					
Malignant melanoma					
Neurologic disease					
Peripheral vascular disease					
Pulmonary embolism					
Rheumatoid arthritis					
Other:					

Social History: (circle one) married single divorced children (if yes, how many? _____)

Occupation / responsibilities: _____ Hours per shift on feet: _____

Faith / Religious preference: _____ History of physical abuse: _____

History of disabling condition: _____ Live with: self others

Tobacco use: cigarettes (____ / day) chewing tobacco pipe Alcohol use: 0-1 2-6 7-12 >12 drinks per week

History of recreational drug use, past or current: _____ History of chemical contact: _____

Review of Systems – please check current symptoms	Yes	No		Yes	No		Yes	No
Acid reflux			Currently pregnant			Nervousness/anxiety		
Back pain			Dark stools			Numbness in feet		
Blackouts			Diarrhea			Radiating leg pain		
Bruise easily			Dry throat/mouth			Shortness of breath		
Calf/leg cramps at night			Fever			Skin rash		
Calf/leg cramps - walking			Fluttering heart			Stiffness/pain in AM		
Chest pain			Frequent urination			Swelling in legs		
Chills			Gout			Unstable on feet		
Cold fingers/toes			Itching			Weight gain		
Cold intolerance			Nausea			Weight loss, unintentional		

*** Please note: we may need to take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, some medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.**

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Signature: _____ **Date:** _____

Patient or legal guardian