

Medical History Questionnaire

Please provide the following information so that we may better serve you.

Name _____

Date _____

Age _____ Shoe Size _____

Which foot is bothering you? _____

How long have the problems existed? _____

Please describe your foot symptoms in detail (use diagram as needed)

Does your pain follow any pattern? (worse @ night, when walking, etc.)

How many hours per day are you on your feet? _____

What have you done so far? (change shoe type, pads, exercise, medicine)

Have you consulted a doctor for this condition? _____

Who and what did the doctor say? _____

Are you a diabetic? Yes or No If so, how many years? _____

Are you on insulin? Yes or No If so, how long on insulin? _____

Do you ever need preventive antibiotics when having your teeth cleaned? _____

Please use diagram to tell us location of foot problems.

Right Foot



Left Foot



Do you have or have you ever been treated for :

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Reflux | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial or leaking valve | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Valve prolapse | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Keloid/thick scars |
| <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> COPD | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> ADD |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hyperthyroid (HIGH) |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Arthritis problems | <input type="checkbox"/> Hypothyroid (LOW) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Lupus | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anemia (type) _____ |

****If you checked any of the above boxes, please explain:(how long, current treatment)** _____

Gout? Yes or No If yes how many attacks? _____

When was last attack? _____

Cancer? Yes or No What type? _____ Year? _____

Type of treatment? _____

****Any other conditions/illnesses?** _____

Current Medications? _____

Medication Allergies? _____

Are you pregnant? _____

Hospitalizations or Surgeries?

1) _____

2) _____

3) _____

4) _____

5) _____

continued on back of sheet

Do you smoke? _____ #Packs/day? _____
If you smoked before, when did you quit? _____
How many alcoholic beverages do you drink per day?

**List any family members who have had:
Diabetes _____
Arthritis _____
Stroke _____
Cancer _____
Foot Problems _____
Birth defects _____
Heart disease _____

High blood pressure _____

Other significant problems _____

For Physician Use

Review of systems

	Yes	No
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>

History Reviewed

No Changes

Physician Signature: _____

Date: _____