## PATIENT DATA / EMERGENCY NUMBERS / INFORMATION

First Name_____ MI:_____ Last Name: _____

Home Address: _____ Your Email:_____

City: _____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Occupation:_____ Employer/School:_____

Date of Birth:_____ Age:_____ Social Security Number: _____

Weight:_____ Height:_____ Shoe size/width:_____ Martial Status: Single ❑ Married ❑ Div. ❑ Other❑ M❑/F❑

In Case of Emergency Call (Name):_____ Phone Number: (_____) _____

Your Preferred Pharmacy (Name):_____ City:_____

Referred By: _____

Family Doctor: _____ City:_____

## PATIENT MEDICAL HISTORY

**Have you been treated for (Circle those that apply):**

| | | |
|---|---|---|
| Ankle injury | Arch pain | Heel pain |
| Lower back pain | Knee pain | Flat feet |
| Childhood foot prob. | High arches | Callouses |
| Broken foot bones | Bunions | Rash |
| Hammertoes | Ingrown nails | Corns |
| Neuroma | None of these | |

**Do you have or have you ever been treated for (Please circle):**

| | | |
|---|---|---|
| Epilepsy | Nerve Disorder | Cancer |
| Depression | Stomach ulcer | Psychiatric disorder |
| Glaucoma | Rheumatic fever | High blood pressure |
| Stroke | Heart attack | Heart disease |
| Trauma | Phlebitis | Liver disease |
| Diabetes | Hepatitis | Kidney disease |
| Anemia | Gout | Asthma |
| None of these | | |

| | | |
|---|---|---|
| **Do you have vascular grafts?** | **Yes** | **No** |
| **Do you have joint implants?** | **Yes** | **No** |
| **Do you have replacement heart valves?** | **Yes** | **No** |
| **Are you now under active chemotherapy?** | **Yes** | **No** |
| **Have you any other serious illnesses?** | **Yes** | **No** |
| **Have you ever been hospitalized or been under medical care very long?** | **Yes** | **No** |
| **Do you consume alcohol?** | **Yes** | **No** |
| **Do you smoke or use products containing nicotine?** | **Yes** | **No** |
| **Packs per day_____** | | |
| **Have you had any surgery (in the last 5 years)?** | **Yes** | **No** |

**Had surgery for:** _____

_____

_____

_____

**Date:**_____

**What is your main foot/ankle problem?**

_____

_____

_____

| | | |
|---|---|---|
| **Are you slow to heal after cuts?** | **Yes** | **No** |
| **Are you currently pregnant?** | **Yes** | **No** |
| **Any abnormal bruising or bleeding?** | **Yes** | **No** |
| **Are you taking insulin?** | **Yes** | **No** |
| **Are you currently taking any medications?** | **Yes** | **No** |

**Medication:**

_____

_____

_____

**Allergies:**

**Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical adminstration of:**

| | | | |
|---|---|---|---|
| **Penicillin or other antibiotic?** | **Yes** | **No** | **Not sure** |
| **Morphine, Codeine, Demerol or other narcotics** | **Yes** | **No** | **Not sure** |
| **Novocaine or other anesthetics?** | **Yes** | **No** | **Not sure** |
| **Aspirin, Empirin or other pain remedies?** | **Yes** | **No** | **Not sure** |
| **Sulfa drugs?** | **Yes** | **No** | **Not sure** |
| **Adhesive tape?** | **Yes** | **No** | **Not sure** |
| **Shrimp, Iodine or Merthiolate?** | **Yes** | **No** | **Not sure** |
| **Latex Rubber?** | **Yes** | **No** | **Not Sure** |
| **Any other allergies?** | **Yes** | **No** | **Not sure** |

**If you answered Yes, list what happens:**

_____

_____

_____

_____

**Updated:** _____