

Patient Podiatric and Health Information

Family Physician: _____ Phone number: _____

Date of last visit: _____ What is the nature of your foot problem?: _____

Height: _____ Weight: _____ Shoe size: _____

Are you in good health?: Yes _____ No _____ If no explain: _____

Do you have lower back pain?: Yes _____ No _____ Sometimes _____

Are your feet tired at the end of the day?: Yes _____ No _____ Sometimes _____

Have you ever broken a bone in your foot or ankle?: Yes _____ No _____

Have you had previous foot or ankle surgery?: Yes _____ No _____

Do you use tobacco products?: Yes _____ No _____ If yes, what amount daily? _____

Medical History

Check if you have or have had any of these medical conditions:

Arthritis, Rheumatism

Eye Trouble

Kidney Problem

Asthma

Heart Problems

Liver Problem

Bleeding Disorder

High Blood Pressure

Swelling of feet/ankle

Cramps or numbness in feet/legs

High Cholesterol

Varicose Veins

Diabetes

HIV

Are you allergic or sensitive to?

Anesthetics

Material

Tape

Drugs

Novocain

Other

Food

Penicillin

Specify: _____

List any medications or vitamins you are currently taking if any: _____
