

Foot Problem or Symptoms: _____
 (Please describe in your own words) _____

How long have you had this problem? _____ Days _____ Weeks _____ Months _____ Years

MEDICAL HISTORY

- | | YES | NO | | YES | NO |
|--|--------------------------|---------------------------------------|----------------------------------|--------------------------|--------------------------|
| 1. HEART PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | 1. HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | 2. LOW BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Other | 3. ULCERS | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | 4. ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes-How Do You Control Your Diabetes | | | 5. GOUT | <input type="checkbox"/> | <input type="checkbox"/> |
| Diet Pills Insulin | | | 6. HIGH CHOLESTEROL LEVELS | <input type="checkbox"/> | <input type="checkbox"/> |
| Any member of family that had diabetes? | | | 7. CANCER (TYPE _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how related? _____ | | | 8. EPILEPSY OR SEIZURE DISORDER | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. LUNG PROBLEMS: | <input type="checkbox"/> | <input type="checkbox"/> | 9. KIDNEY PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | 10. THYROID CONDITION | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 11. GLAUCOMA | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | 12. HISTORY OF RHEUMATIC FEVER | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | 13. ARTIFICIAL JOINT REPLACEMENT | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Premedication Necessary? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | 14. IMMUNE SYSTEM DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. LIVER PROBLEMS: | <input type="checkbox"/> | <input type="checkbox"/> | (Aids, HIV, ARC) | | |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 15. VENEREAL DISEASE | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 16. ANEMIA | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | 17. PRONE TO INFECTION | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. CIRCULATION PROBLEMS: | <input type="checkbox"/> | <input type="checkbox"/> | 18. SCAR PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | 19. BLEEDING DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> |
| Phlebitis (Blood Clots) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Peripheral Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Poor Circulation | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Shoe Size _____ Height _____ Weight _____

Pharmacy Name: _____

Any Other Medical Problems? YES NO
 If Yes-Please List _____

Physician Name: _____

Date of Last Visit: _____

Past or Present Surgeries? YES NO
 If Yes-Please List _____

If Yes-Please list or provide a list: _____

Are you presently taking any medication? YES NO
 Do you have any medication allergies? _____

Allergies to adhesive tape or metals (Circle of Applicable)

Do You Smoke? YES NO
 Do You Consume Alcoholic Beverages? YES NO
 Do You Consume Caffeinated Beverages? YES NO

If Yes-How Much _____ How Many Years _____

If Yes-How Much Per Day/Week _____

If Yes-How Much Per Day/Week _____

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

Outside/Athletic Activities? _____