



HISTORY AND MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician: _____

Date of last primary care visit: _____

Height: _____ **Weight:** _____

Foot/Ankle Issue(s): _____

How long has it been going on? Any injury? _____

What treatment have you tried? _____

Medical History – Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Addiction Issues (Substance? _____) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> History of Falls |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Inflammatory Bowel Disease
(Crohn's/Ulcerative Colitis) |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Kidney Disease (Stage? _____) |
| <input type="checkbox"/> Birth Defect (Specify: _____) | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Bleeding Disorders (Specify: _____) | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Blood Clots (Where and when? _____) | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Brain Injury (When? _____) | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Breastfeeding (Current) | <input type="checkbox"/> Osteoarthritis (Where? _____) |
| <input type="checkbox"/> Cancer (Specify: _____) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Circulation Issues (Where? _____) | <input type="checkbox"/> Pregnancy (Current) |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Raynaud's Syndrome |
| <input type="checkbox"/> Diabetes (How long? _____ A1C? _____) | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eye Disease (Specify: _____) | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Foot Ulcers | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease (History of heart attack?
Yes/No) | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |

Continued on other side →

Medications:

List all medications/vitamins/supplements with dosages: _____

Allergies

List all allergies with the reaction including those to medication, food, and environment: _____

Surgical History

List surgeries and years: _____

Side effects to anesthesia? Yes/No If yes, explain: _____

Family History

List medical conditions of immediate family members (grandparents, parents, siblings, children) and include their relation to the patient

Maternal Side: _____

Paternal Side: _____

Social History

Check all that apply:

- Tobacco use – Current or past? _____ How long? _____ How much? _____
- Alcohol use – Current or past? _____ How long? _____ How much? _____
- Drug use - Current or past? _____ How long? _____ How much? _____

Do you exercise? If so, what activities and how often? _____

Occupation: _____

Marital Status: _____