MEDICAL HISTORY

Have you visited a podiatrist before? ❑ Yes ❑ No | If yes, when was your last visit?

Do you have any personal or family history of diabetes? ❑ Yes ❑ No

Please indicate which foot problems you currently have:

Fungus?	❑ Yes ❑ No	Heel Pain?	❑ Yes ❑ No	Foot odor?	❑ Yes ❑ No
Ingrown toenails?	❑ Yes ❑ No	Swelling?	❑ Yes ❑ No	Bunions?	❑ Yes ❑ No
Ankle Pain?	❑ Yes ❑ No	Cramps/Numbness?	❑ Yes ❑ No	Flat Feet?	❑ Yes ❑ No
Tired Feet?	❑ Yes ❑ No	Athlete's Foot?	❑ Yes ❑ No	Warts?	❑ Yes ❑ No
Itchy Feet?	❑ Yes ❑ No	Foor or leg cramps?	❑ Yes ❑ No	Callouses?	❑ Yes ❑ No

Do you have any of the following?

Diabetes?	❑ Yes ❑ No	High Blood Pressure?	❑ Yes ❑ No	Arthritis?	❑ Yes ❑ No

Family Physician: _____ Phone Number: _____

(If applicable) Are you pregnant? ❑ Yes ❑ No If yes, how many months? _____

MEDICATIONS

Include prescriptions, over the counter medications, and vitamins:

ALLERGIES

Please list all allergies to medications:

CONSENT

I certify that the above informatin is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures essential in the diagnosis and/or treatment of my feet, and release all medical information as may be deemed necessary.

Patient / Guardian Signature		*Date*	