Health History

Full Name _____ Date of Birth _____

Age _____ Height _____ Weight _____lbs. Shoe Size _____

Reason for your visit: _____

Where is your pain/injury? *(check all that apply)* □ Left □ Right □ Foot □ Ankle □Toe □ _____

What caused this problem? _____

How long has this bothered you? _____

What aggravates It? _____

What have you tried to relieve the problem? _____

Has another physician previously treated you for this problem? □ Yes □ No Dr. _____

Quality/Severity of pain? *(check all that apply)*

□ Mild □ Moderate □ Severe
□ Sharp □ Dull □ Achy
□ Burning □ Numbness □ Pins/needles

On a scale of 1-10 how would you rate your pain today? _____ 1---2----3----4----5----6----7----8----9---10

GENERAL HEALTH

If you have had or currently have any of the following, check all that apply:

□ Pacemaker
□ Heart Disease
□ High Blood Pressure
□ Neuropathy
□ HIV/AIDS
□ Kidney Disease
□ Anemia
□ Lung Disease
□ Burning/Numbness: feet/legs
□ Lower back pain
□ Cramping: feet/legs
□ Use of anticoagulants
□ Lymph Disease

□ Epilepsy
□ Arthritis
□ Varicose Veins
□ Diabetes
□ Thyroid Disease
□ Gout
□ Hepatitis
□ Cancer Specify: _____
□ Currently undergoing treatment OR □ History of
□ Metal Implants Specify: _____
□ Hemophilia Specify: _____
□ Joint replacement Specify:_____

HOSPITALIZATIONS & SURGERIES

Surgical Procedure/Serious Illness	Year	Physician	Hospital

Continued on back →

Health History

Do you smoke? □ No □ Yes (give details)

Type of smoking (cigarette, chew, etc.) _____

How much do you smoke per day _____

How long have you smoked _____

Are you interested in quitting? □ Yes □ No

Do you exercise? □ No □ Yes (give details)

Type _____

Duration (how long)_____

Frequency (how often)_____

Are you interested in losing weight? □ Yes □ No

Do you drink alcohol? □ No □ Yes (give details)

□ Daily □ Socially □ Rarely

Amount of alcohol consumed per week _____

What is/was your occupation? _____

Average # of hours per day you stand at work _____

What kind of shoes do you wear at work _____

CURRENT MEDICATIONS

Please list all prescriptions and over-the-counter medications and their dosages:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES (*Allergy or Sensitivity)*

□ **No Allergies**

□ Sulfa Reaction: _____

□ Penicillin Reaction: _____

□ Adhesive/Tape Reaction: _____

□ Latex Reaction: _____

□ _____ Reaction: _____

□ _____ Reaction: _____

Have you ever had a bad reaction to general or local anesthetic? □ Yes □ No

If yes, give details _____

PHYSICIAN'S

Primary: _____

Date of last visit with primary: _____

Endocrinologist: _____

Nephrologist: _____

Cardiologist: _____

Oncologist: _____

PHARMACY

Preferred Pharmacy: _____ Phone: _____

Address: _____

How did you hear about our office?

□ Friend □ Family □ Internet □ Phone Book □ Physician Referral □ Other _____