

MEDICAL AND PODIATRIC INFORMATION

Patient's Name _____ Date _____

Personal Physician _____ Last seen _____

Previous Podiatrist _____ Last seen _____

Are you in generally good health? Yes No

Are you taking any medications? Yes No

If yes, please name _____

Have you had a previous illness in the past year? Yes No

If yes, please name _____

Have you been hospitalized in the past year Yes No

If yes, please name _____

I AM ALLERGIC TO OR HAD A REACTION TO: (please check)

Adhesive tape Penicillin Codeine Novocain

Tetanus shot Other (please specify) _____

I OR A FAMILY MEMBER HAVE HAD OR CURRENTLY HAVE (please check)

	Yourself	Family Member
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Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
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Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>
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Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
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Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
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Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
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Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>
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Stroke	<input type="checkbox"/>	<input type="checkbox"/>
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High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
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Intestinal ulcers	<input type="checkbox"/>	<input type="checkbox"/>
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Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
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Anemia	<input type="checkbox"/>	<input type="checkbox"/>
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Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
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AIDS	<input type="checkbox"/>	<input type="checkbox"/>
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Other _____		
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Are you pregnant Yes No

What is your chief foot problem or concern? _____

Signature

Date