20_____

First Visit Information

PLEASE PRINT CLEARLY

Name: _____

Why are we seeing you today? _____

How long has this been a problem? _____ Which foot: right left both

Shoe size: _____ Height: _____ Weight: _____

Medical / Family History

Please circle to indicate "Y" (yes) or "N" (no). **Please describe details of any "Yes" answer.**

Self	Family		Self	Family	
Y N	Y N	Anemia? _____	Y N	Y N	Neurologic disorders? Type _____
Y N	Y N	Arthritis? Type _____	Y N	Y N	Osteoporosis? _____
Y N	Y N	Asthma? _____	Y N	Y N	Phlebitis / Blood clots / Pulmonary embolus
Y N	Y N	Cancer? Type _____			_____
Y N	Y N	Diabetes? Date of diagnosis _____	Y N	Y N	Psychiatric disorders? Type _____
Y N	Y N	Excessive bleeding? _____	Y N	Y N	Rheumatic fever? _____
Y N	Y N	HIV or AIDS? _____	Y N	Y N	Murmur? _____
Y N	Y N	Healing problems? _____	Y N	Y N	Stomach ulcers / peptic ulcers?_____
Y N	Y N	Heart attack? Date _____	Y N	Y N	Stroke? _____
Y N	Y N	Heart failure? _____	Y N	Y N	Thyroid disease? _____
Y N	Y N	Hepatitis? A, B, C or other _____	Y N	Y N	Do you have any metal implants, plates, pins or screws? _____
Y N	Y N	High Blood Pressure? _____			
Y N	Y N	Kidney problems? _____			Please list any other medical condition you have not listed
Y N	Y N	Liver problems? _____			above (i.e., High Cholesterol): _____
Y N	Y N	Lung disease?			_____
		Circle type: COPD Emphysema			_____

Please answer the following questions:

List all allergies to medications, adhesive tape, or latex:

_____

_____

Please list any medications you take and dosage:

_____

_____

Please list surgeries and hospitalizations:

_____

_____

Do you or have you ever used tobacco products? yes no Type _____Packs per day ___Years ___Quit _____

Do you drink alcohol? yes no Amount per day _____

Do you drink caffeinated beverages? Amount per day _____

Any recreational drug use? _____

Please list any physicians who have treated your feet, and when:

_____

_____

(Women) Are you pregnant? yes no Are you breastfeeding? yes no