FEET FIRST, INC.

MEDICAL HISTORY FORM

NAME_____DATE_____

BRIEFLY SUMMARIZE YOUR FOOT CONCERNS:_____

_____

_____

HOW LONG?_____ AnY PREVIOUS TREATMENT?_____

HAS ANY X-RAYS BEEN TAKEN? YES OR NO.

PLEASE CIRCLE YES OR NO. IF YOU HAVE ANY OF THE FOLLOWING:

DIABETES	YES OR NO	MITRAL VALVE PROLAPSE	YES OR NO
HEART CONDITION	YES OR NO	SWELLING IN LEGS/FEET	YES OR NO
LIVER CONDITION	YES OR NO	CIRCULATION DISORDER	YES OR NO
KIDNEY CONDITION	YES OR NO	RHEUMATIC FEVER	YES OR NO
LUNG CONDITION	YES OR NO	BLOOD CLOT	YES OR NO
BLEEDING DISORDER	YES OR NO	PHLEBITIS	YES OR NO
ULCER	YES OR NO	ASTHMA	YES OR NO
CANCER_____	YES OR NO	ARTHRITIS	YES OR NO
GOUT	YES OR NO	EPILEPSY	YES OR NO
FOOT/LEG CRAMPS	YES OR NO		

PLEASE LIST ANY SURGERIES YOU HAVE HAD:_____

_____

HOSPITALIZATIONS OTHER THAN FOR SURGERIES:_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	STRENGTH/DOSES	FREQUENCY (doses/dav)

ALLERGIES (please check all that apply)

☐ NONE KNOWN	☐ CODEINE	☐ LATEX	☐ OTHER:_____
☐ PENICILLIN	☐ ASPIRIN	☐ LOCAL ANESTHETICS	
☐ NOVOCAIN	☐ ADHESIVE TAPE	☐ SEAFOOD/SHELLFISH	
☐ ANESTHETICS	☐ SULFA	☐ IODINE	

*** ARE YOU PREGNANT?** YES OR NO

***CIGARETTE/TOBACCO USE:** YES OR NO # OF YEARS_____ALCOHOL USE: YES OR NO