PATIENT NAME_________________________ **DATE**_______________

MEDICAL HISTORY

HAVE YOU HAD A HISTORY OF ANY OF THE CONDITIONS BELOW? IF YOU HAVE, PLEASE CIRCLE EACH ONE AND EXPLAIN FURTHER:

HEART DISEASE/HYPERTENSION__________________________________

ARTHRITIS____

JOINT AND MUSCLE PAIN____

PAIN IN FEET OR LEGS WALKING__________________________________

DIABETES____

GOUT____

CIRCULATION PROBLEMS____

SKIN PROBLEMS____

CANCER____

VISION PROBLEMS ____

HEARING PROBLEMS____

BLEEDING PROBLEMS____

SLOW TO HEAL ____

GANGRENE/AMPUTATION____

OTHER____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS/TAPE/LATEX

____

____

PLEASE LIST MEDICATIONS YOU ARE TAKING, INCLUDING HERBS

____

____

____

____

____

____

PLEASE LIST ANY OPERATIONS YOU HAVE HAD AND THE YEAR OF THE OPERATION ____

____

____

____

____

____

PLEASE LIST ANY OTHER FOOT PROBLEM YOU HAVE HAD/TREATMENT/YEAR/DOCTOR

____

____

____

____