



Name \_\_\_\_\_

Date \_\_\_\_\_ Gender M or F

Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight \_\_\_\_\_ lbs

Shoe size \_\_\_\_\_ Medium or Wide

Please use circles and arrows on picture to the left to indicate painful, injured or problem area(s).

Describe current problem: \_\_\_\_\_

\_\_\_\_\_ When did problem start? \_\_\_\_\_

Employment: ( ) sits at job ( ) stands at job ( ) stands and walks at job Have you ever had a foot/skin ulcer? Y N

Have you had foot treatment before? Y N By whom? \_\_\_\_\_ When? \_\_\_\_\_

Are you being treated for diabetes now or in the past? Y N How long have you had diabetes? \_\_\_\_\_

Type of treatment: ( ) diet ( ) oral Insulin \_\_\_\_\_ units per day Blood sugar today \_\_\_\_\_

Do you smoke: Y N #packs/day \_\_\_\_\_ Previously smoked # of years \_\_\_\_\_

Do you drink alcohol: Y N light / heavy?

Are you under a physician's care? Y N For what condition? \_\_\_\_\_

Current medication list: \_\_\_\_\_

Over the counter medications: \_\_\_\_\_

\_\_\_\_\_ Birth control? Y N

**ALLERGIES:** ( ) NONE ( ) Sulpha drugs ( ) Aspirin ( ) Local Anesthetics  
( ) Codeine ( ) Tape ( ) Latex ( ) Other Antibiotics  
( ) Iodine/Shellfish ( ) Non-Steriodal Medications ( ) Penicillin  
( ) OTHER \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Have you been told by a doctor to take antibiotics before any dental or surgical procedure? Y N

Do you have a pacemaker? Y N Do you have artificial heart valves? Y N

Do you have artificial joints? Y N Hip R L Knee R L

Previous Injuries:	Previous Surgeries:	Previous Hospitalizations:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____