Last Name _____ First Name _____ M.I. _____ Date _____
Referred by: _____ Email Address _____
What condition brought you into the office? _____
Duration? _____ Cause? _____
Personal Physician _____ **Pharmacy Name _____**
Address _____ **Pharmacy Phone _____**
Phone _____
How did you find out about us? _____

Is your health: Good _____ Fair _____ Poor _____?
Age _____ Height _____ Weight _____ Shoe Size _____ Shoe Width _____

Circle illnesses that you have had, then date Personal History:

	Date		**Date**		**Date**
Mumps		Pneumonia		Stomach/Ulcers	
Chicken Pox		Tuberculosis		Intestinal Problems	
Measles		Asthma		Hepatitis/Liver	
Whooping Cough		Bronchitis		Kidney Disease	
Scarlet Fever		Emphysema		Thyroid Disease	
Smallpox/Polio		Pleurisy		Bladder/Cystitis	
Hypertension		Stroke		Recent Infections	
Diabetes		Gout		Blood Problems	
(Hemaglobin A1c)		Arthritis		Seizures	
Heart Disease		Cancer		Phlebitis/Blood Clot	
Rheumatic Fever		Allergies		Auto Immune Disease	
Venereal Disease				(Specify types)	

Women - Are you pregnant? Yes _____ No _____
Please List All Medication that you are currently taking:

Name of Medication Dosage and frequency Used for
_____
_____
_____
_____

Vaccine:

	Date
Flu	
Covid	
Pneumonia	

List All Surgical Operations, Hospitalizations or Injuries:
_____
_____
_____

Allergies, Check the following: I have no known allergies _____
Aspirin ( ) Penicillin ( ) Iodine ( ) Codeine ( ) Sulfa Drugs ( ) Local Anesthetics ( ) Adhesive Tape ( )
Morphine ( ) Other _____

Family History: Age, Health, Illnesses
Mother _____
Father _____
Brother _____
Sister _____

Social History:
Tobacco: Type _____
Years _____ Packs/day _____
Alcohol _____
Drugs _____

Familial History of Foot Problems _____
Familial History of Anesthetic Reactions _____