Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Height _____ Weight _____ Shoe Size _____ Shoe Width _____
Phone Number (_____) _____
Email Address _____
What condition brought you into the office? _____
How did you find out about us? _____
Primary Care Physician_____

Pharmacy Name _____ Pharmacy Phone _____

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 (Hemaglobin A1c)		Gout		Blood Problems	
		Arthritis		Seizures	
		Cancer		Phlebitis/Blood Clot	
		Heart Disease		Auto Immune Disease (Specify types)	
		Rheumatic Fever			
		Venereal Disease			

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 ( )
Other _____

Family History: Age, Health, Illnesses
Familial History of Foot Problems _____
Familial History of Anesthetic Reactions _____
Parents _____
Sibling _____

Social History:
Tobacco: Years _____ Packs/day _____
Alcohol _____
Recreational substance _____