MEDICAL HISTORY **PATIENT'S NAME: ____________________ DOB: ____________**

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (please mark all)**:**

Condition		Condition		Condition	
AIDS/HIV	__YES__NO	DIFFICULT / SLOW HEALING	__YES__NO	RADIATION /CHEMO	__YES__NO
ALCOHOLISM	__YES__NO	EAR PROBLEMS	__YES__NO	RESPIRATORY DISEASE	__YES__NO
ANEMIA	__YES__NO	EPILEPSY	__YES__NO	RHEUMATIC FEVER	__YES__NO
ANGINA	__YES__NO	EYE PROBLEMS	__YES__NO	SCIATICA	__YES__NO
ARTHRITIS (OSTEO / RA)	__YES__NO	FAINTING	__YES__NO	SEIZURES / CONVULSIONS	__YES__NO
ARTIFICIAL HEART VALVES		GALL BLADDER DISEASE	__YES__NO	SHORTNESS OF BREATH	__YES__NO
OR JOINTS	__YES__NO	GLAUCOMA	__YES__NO	SINUS PROBLEMS	__YES__NO
ASTHMA	__YES__NO	GOUT	__YES__NO	SKIN RASH	__YES__NO
BLOOD D/O OR TRANSFUSION	__YES__NO	HEADACHES	__YES__NO	SPECIAL DIET	__YES__NO
BLOOD PRESSURE	HIGH / LOW	HEART DISEASE / TROUBLE	__YES__NO	STOMACH TROUBLE	__YES__NO
BY PASS (LEGS / HEART)	__YES__NO	HEMOPHILIA	__YES__NO	STROKE	__YES__NO
CANCER	__YES__NO	HEPATITIS OR JAUNDICE	__YES__NO	SWELLING IN FEET,ANKLES	__YES__NO
CHEMICAL DEPENDENCY	__YES__NO	HIATAL HERNIA (GERD)	__YES__NO	SWOLLEN NECK GLANDS	__YES__NO
CHEST PAIN	__YES__NO	JOINT PAIN / STIFFNESS	__YES__NO	THYROID (GOITER)	__YES__NO
CHOLESTEROL (HIGH/LOW)	__YES__NO	KIDNEY PROBLEMS (S L)	__YES__NO	TIRED FEET	__YES__NO
CHRONIC DIARRHEA	__YES__NO	LIVER DISEASE	__YES__NO	TUBERCULOSIS	__YES__NO
CIRCULATORY PROBLEMS	__YES__NO	LUNG PROBLEMS	__YES__NO	TUMOR(S)	__YES__NO
CONSTIPATION	__YES__NO	MUSCLE PAIN / STIFFNESS	__YES__NO	ULCERS (S L F)	__YES__NO
CRAMPING / TIGHTNESS:	__YES__NO	NERVE DISORDER	__YES__NO	URINATION PROBLEMS	__YES__NO
THIGH(S) (A R N)	__YES__NO	NUMBNESS: **LEGS/FEET/TOES**	__YES__NO	VARICOSE VEINS	__YES__NO
LEG(S) (A R N)	__YES__NO	OSTEOPOROSIS	__YES__NO	VENEREAL DISEASE	__YES__NO
FEET (A R N)	__YES__NO	PHLEBITIS / BLOOD CLOTS	__YES__NO	WEIGHT CHANGES	LOSS GAIN
DEMENTIA/ALZHEIMERS	__YES__NO	POLIO	__YES__NO	(UNEXPLAINED)	__YES__NO
DIABETES (D P I)	__YES__NO	PSYCHIATRIC CARE	__YES__NO	NERVOUS PROBLEMS	__YES__NO

IF YOU CHECKED **YES** TO ANY OF THE ABOVE CONDITIONS, **PLEASE COMMENT AND GIVE APPROXIMATE DATE**:

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SURGERIES: HAVE YOU EVER BEEN HOSPITALIZED FOR OVER 24 HRS? IF YES, GIVE APPROXIMATE DATE, SURGEON, HOSPITAL / PLEASE INCLUDE SERIOUS INJURIES:

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HAVE YOU HAD PAIN IN OTHER AREAS NOT PREVIOUSLY IDENTIFIED: **(I.E. BACK)** __YES__NO
IF YES, PLEASE DESCRIBE THIS ILLNESS OR PROBLEM: ______________________________________

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FAMILY HISTORY:

Condition		Condition		Condition	
ALLERGIES	__YES__NO	HEART TROUBLE	__YES__NO	ENDOCRINE DISORDERS	__YES__NO
ARTHRITIS	__YES__NO	KIDNEY DISEASE	__YES__NO	DIABETES	__YES__NO
CANCER	__YES__NO	STROKES	__YES__NO	HEMOPHILIA	__YES__NO
TUBERCULOSIS	__YES__NO	HIGH BLOOD PRESSURE	__YES__NO	(BLEEDING DISORDER)	
BIRTH DEFECTS	__YES__NO	FOOT PROBLEMS	__YES__NO		

ALLERGIES: (Circle all that apply to you)

ADHESIVE TAPE	ANTIBIOTICS	ASPIRIN LIKE MEDICATIONS	IODINE
PAIN PILLS	LOCAL ANESTHETICS	ANTI COAGULANT THERAPY	CORTISONE

SPECIFICS: (i.e. Foods or other medications) ______________________________________

I understand that honest and complete answers to each question above are important to the provision of my medical care; the information I have given is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the staff for assistance.
I understand that the use of drugs, prescribed or otherwise, including alcohol and tobacco, the abuse of the same (both past and present), or the existence of conditions such as pregnancy, epilepsy, herpes, AIDS or others not disclosed by me to the doctor or his assistants may affect his recommendation as to treatment or alternative forms of treatment and I assume all risks, which may exist as a result of my failure or refusal to disclose such matters prior to treatment. I give my permission to Dr. Don Tupper, Podiatrist, to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I authorize the release of any medical or other information necessary to process and retrieve payments for medical benefits that I generate for services rendered.

PATIENT / GUARDIAN SIGNATURE____________________________________DATE______________