Patient Name____pharmacy & location______________________________

Weight______________Height______________Sex______________Age______________Shoe Size_____________

Race & ethnicity______________________________________primary language______________________________

Primary care doctor & phone no#____date of last visit___________________

Please indicate the nature of any problems or conditions with your feet or related leg structure________________________

____

Do you have allergies to medicines..if yes..please indicate reason____

____

Please list medications you are taking____

____

Have you ever been hospitalized or had operations..if yes..please indicate date, hospital & reason____________________

____

Have you had any broken bones or other injuries____

____

Have you had or have any of the following..please check the appropriate boxes:

______Diabetes (sugar)	______Hepatitis	______Leg cramps/numbness
______Anemia (weak/tired blood)	______Liver problems	______Tumors
______Bleeding problems	______Varicose veins	______Gout
______Epilepsy	______Asthma/breathing problems	______Fainting spells
______Heart problems	______Glaucoma/eye problems	______High blood pressure
______Rheumatic fever	______Kidney problems	______Stomach ulcer
______Nervousness	______Rheumatism/arthritis	______Swelling of ankles
______Stroke	______Tuberculosis	______Neuro-muscular problems
______Cancer	______Venereal disease	

Is there any family history of ( )Gout ( )Cancer ( )High blood pressure ( )Arthritis ( )Diabetes ( )Heart attacks

Do you smoke..if yes..how much__________________________Do you drink alcohol..if yes..how much________________

Is there anything else we should know about your general health status____

____

Patient signature____date________________