

MEDICAL HISTORY

Name: _____ Birth date: _____

Please circle "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Hemophilia	YES	NO
Allergies to anesthetics	YES	NO	Hepatitis or jaundice	YES	NO
Allergies to medicine or drugs	YES	NO	High blood pressure	YES	NO
Anemia	YES	NO	Kidney problems	YES	NO
Angina	YES	NO	Liver disease	YES	NO
Arthritis	YES	NO	Low blood pressure	YES	NO
Artificial heart valves or joints	YES	NO	Neuropathy	YES	NO
Asthma	YES	NO	Phlebitis	YES	NO
Back problems	YES	NO	Radiation Treatment	YES	NO
Bleeding disorders	YES	NO	Rash	YES	NO
Cancer	YES	NO	Respiratory disease	YES	NO
Chemical dependency	YES	NO	Rheumatic fever	YES	NO
Chest pain	YES	NO	Shortness of breath	YES	NO
Chronic Diarrhea	YES	NO	Sinus problems	YES	NO
Circulatory problems	YES	NO	Special diet	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Ear problems	YES	NO	Swelling in ankles	YES	NO
Epilepsy	YES	NO	Swelling in feet	YES	NO
Eye problems	YES	NO	Swollen neck glands	YES	NO
Fainting	YES	NO	Tired feet	YES	NO
Foot or leg cramps	YES	NO	Tuberculosis	YES	NO
Gout	YES	NO	Ulcers	YES	NO
Headaches	YES	NO	Varicose veins	YES	NO
Heart disease	YES	NO	Venereal disease	YES	NO
			Weight loss unexplai	YES	NO

Is there any personal or family history of diabetes? YES NO

IF YOU ARE A DIABETIC PLEASE ANSWER THE FOLLOWING?

IF NOT THEN SKIP DOWN TO MEDICATIONS.

If you are a diabetic have you ever had any feet ulcers? YES NO

Have you ever had any amputations? YES NO

Have any family members had amputations or feet ulcers? YES NO

How often do you check your blood sugars? _____

What are they normally? _____

How do you control your blood sugars (circle) PILLS INSULIN OTHER _____

Have you ever had DIABETIC SHOES? YES NO

If Yes when? _____

MEDICATIONS: (include prescriptions, over-the-counter medications and vitamins) _____

Do you take oral contraceptives? YES NO

Pharmacy Name and Phone number? _____