Patient Medical History

Patient Name: _____Weight: _____lbs. Height: _____ Birthdate: _____

Foot Complaint: _____

HEART

☐ Heart Attack (MI)/Angina-Date:
☐ Coronary Bypass/Stent-Date:
☐ Pacemaker-Type: _____
☐ Coronary Heart Disease
☐ Congestive Heart Failure
☐ Mitral Valve Prolapse
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Murmur
☐ Arrhythmia/(A-Fib)
☐ On blood thinners
Type: _____
☐ Anemia/Bleeding/Clotting Disorder
☐ Blood Clots/DVT/Pulmonary
☐ High Cholesterol

Can you climb a flight of stairs without chest pain, shortness of breath, dizzy, lightheaded? ☐ Yes ☐No

LUNG

☐ COPD
☐ Asthma/Daily inhalers? ☐ Yes ☐No
☐ Emphysema
☐ Breathing Problems/Shortness of Breath
☐ On Supplemental Oxygen
☐ Sleep Apnea: Use of C-pap, B-pap, Dental Appliance, Surgical Implant

NEUROLOGICAL

☐ Stroke/TIA/Brain Aneurysm
Date: _____
☐ Migraines/Headaches
☐ Epilepsy/Seizures/Convulsions
☐ Alzheimer Disease
☐ Parkinson Disease
☐ Numbness or tingling in lower legs
☐ Weakness in Legs/Arms
☐ Restless Legs Syndrome
☐ Chronic Pain Syndrome

ENDOCRINE

☐ Diabetes-Type I, II
☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease
☐ Kidney Disease/ESRD/Dialysis
☐ Liver Disease
☐ Thyroid Disease: Hypo/Hyper
☐ Autoimmune Disease
☐ Multiple Sclerosis
☐ Lupus Disease
☐ Gout
☐GERD/Reflux/Barrett's Disease
☐Ulcerative Colitis/Crohn's/IBS Disease

INFECTIOUS DISEASE

☐ Tuberculosis Date: _____
Treatment Completed: ☐ Yes ☐No
Date: _____
☐ COVID Date: _____
Fully Vaccinated: ☐ Yes ☐No
Boosters: ☐ Yes ☐No
☐ MRSA/C-Diff
☐ Hepatitis A, B, C

MUSCULOSKELETAL

☐ Joint Replacement-Hip, Knee
☐ Neck Pain
☐ Back Pain
☐ Muscular Dystrophy
☐ Osteoporosis
☐ Osteopenia
☐ Arthritis
☐ Fibromyalgia
☐ Obesity
☐ Foot Ulcers/Wounds
☐ Edema
☐ Varicose Veins

EYE

☐ Glaucoma
☐ Retinal Detachment
☐Macular Degeneration

CANCER

Type: _____
Previous Chemotherapy
Date of last treatment: _____
Previous Radiation
Date of last treatment: _____

Psychological

☐ Anxiety/Depression
☐ Alcoholism/Drug Abuse

COMPLETE BOTH SIDES

Smoking Status: ☐ Never ☐ current smoker/ppd: _____ ☐Former smoker

Drink alcohol/ETOH use: ☐ None ☐Social ☐Moderate ☐Heavy

Do you use **cannabis** products? If yes, Type: _____ How much: _____ How Often: _____

Please List ALL medications including prescriptions, over the counter, blood thinners, and vitamins. ☐ NONE

Name of Medication	Dose	How Often

Please list ALL allergies including medications, contrast dye, metal, latex, adhesive tapes. ☐ No Known Drug Allergies

Allergies	Reaction

Please list ALL previous surgeries. **☐ NONE**

Past Surgery	Date

The above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

COMPLETE BOTH SIDES