

Patient Name: _____ Today's Date: _____

MEDICAL INFORMATION

PERSONAL PHYSICIAN: _____ PHYSICIAN'S LOCATION: _____

CHIEF FOOT / ANKLE / LEG PROBLEM (S): _____

ONSET AND DURATION OF PROBLEM: _____

PAST TREATMENT: _____

AGGRAVATING AND / OR RELIEVING FACTORS: _____

MEDICAL HISTORY

(please circle conditions that apply)
(our nurse can assist you if desired)

GENERAL MEDICAL:

How are you feeling today? _____ Any fever, chills, body aches, weight changes? _____

Diabetes, Heart Disease, Hypertension, Chest Pain, Angina, Heart Attack, Mitral Valve Prolapse, Murmur, Arrhythmia, Stroke, Hepatitis, HIV/Aids, Elevated Cholesterol or Lipids, Cancer, _____

RESPIRATORY:

Asthma, Bronchitis, Emphysema, COPD, Shortness of Breath, Lung Disease or Breathing Problems, Tuberculosis, _____

HEENT:

Sinus Problems or Infections, Tonsillitis or Throat Infections, Glaucoma, Eye or Vision Problems, Frequent Headaches/ Migraines, Hearing Deficit, _____

GASTRO-INTESTINAL:

Ulcers, Reflux, Heartburn, Hiatal Hernia, Stomach Disorder, Bowel Disorder, Irritable Bowel Syndrome, Crohn's Disease, GI or Rectal Bleeding, _____

GENITO-URINARY:

Kidney or Bladder Infection, Kidney Problems, Venereal Disease, Prostate Conditions, _____

VASCULAR DISEASE / BLOOD DISORDERS:

Poor Circulation (PAD), Leg Cramps With Walking, Varicose Veins, Phlebitis, Leg Ulcers, History of Blood Clots to Legs, Bleeding or Clotting Disorder, Anemia, Sickle Cell Disease, _____

PLEASE TURN PAGE OVER; CONTINUE ON BACK