

MEDICAL HISTORY

1.) What's the reason for today's visit? _____

2.) Are you in good health? Yes No

3.) Are you under care by a physician? Yes No

If yes for what? _____

4.) Do you smoke or use tobacco? Yes No

5.) Females are you pregnant at this time? Yes No

6.) Have you ever been seriously injured? Yes No

If yes for what? _____

7.) Do you know or have been treated for: (please circle)

Diabetes

Heart Trouble

Lung Problems

Cancer

High blood Pressure

Stroke

Kidney Disease

Liver Problems/Hepatitis

Rheumatoid Fever

Blood Disorders

Vascular Disease/Poor Circulation

Varicose Veins

Phlebitis

Stomach Ulcers

Gout

Arthritis

Asthma

Other: _____

8.) List any previous surgeries done in a hospital and when:

9.) What medications do you take now?

10.) Are you allergic to any medications: Yes No

If yes to what? _____

11.) Have you had any previous vascular studies performed: Yes No

If yes when? _____

12.) What kind of work do you do? _____

13.) Do you enjoy any special sports activities or any hobbies? Yes No

14.) What is your shoe size? _____

****For Diabetic Patients please answer the questions below:**

1.) Is your diabetes under control? Yes No

2.) What doctor is treating your diabetes? _____

3.) Do you have any foot/ankle ulcers or any open wounds at this time? Yes No

If yes where? _____

Signature: _____ Date: _____