--CONFIDENTIAL MEDICAL HISTORY--

PATIENTS NAME: _____

Please briefly describe the nature of your foot complaints: _____

_____

_____

Who referred you to us? _____

Do you consider yourself in good health? yes no

Are you now or have you been under a physicians care during the past two years? yes no

If yes, for what? _____

What medications are you currently taking? _____

_____

(If you have a list we will copy it for you)

Are you taking any blood thinners such as COUMADIN? yes no

Are you taking birth control pills? yes no

Do you smoke? _____ How much? _____

Any history of vascular, blood vessel or circulation problems? yes no

Are you subject to prolonged or a "free bleeder" ? yes no

Is there a family history of DIABETES (Sugar)? yes no

Are you Diabetic? _____ If yes, is your sugar under control? _____

Have you ever experienced bad side effects or allergies from any medications, antibiotics, tape, topical medications, creams or anesthetics (numbing medicine)? yes no

If yes, what and when? _____

_____

Do you faint, get nauseous or sick when getting a shot or with the sight of blood? yes no

Have you ever been treated for HEART TROUBLE, ASTHMA, EPILEPSY,

RHEUMATIC FEVER, KIDNEY or LIVER disorders? (circle condition)

Have you ever had any form of HEPATITIS? yes no

Have you ever had a skin ulcer, sore, or incision that would not heal? yes no

Have you ever had a blood transfusion? yes no

Have you been diagnosed as having HIV or AIDS? yes no

Are you or do you think you may be pregnant? yes no

Please give us a summary of your various operations and dates _____

_____

_____

Patient Signature _____ Date _____

(If patient is under 18 this must be signed by parent or guardian)