Medical Information / Patient Name: **Date:**

Did someone refer you to my office?

Who is your Primary Medical Doctor?

Chief Complaint (Briefly Describe): 1)

2)

How long have you been suffering? Days Weeks Months Years

How did it start (circle): Gradual Sudden Result of Injury With Exercise With a New Job Other:

Course: getting better getting worse no change **Aggravating Factors:**

Have you treated the Condition (Circle): Rest Ice Ibuprofen Aleve Tylenol Shoe Modification Other:

Past Medical History: (Please circle all that apply) **____(check) I HAVE NO MEDICAL CONDITIONS**

High Blood Pressure	Asthma	Psoriasis	Blood Disorder
Heart Disease	Emphysema	Eczema	Melanoma
Coronary Art Disease	Kidney Disease	History of Gout	Skin Cancer
Heart Attack:_____	Dialysis	Psoriatic Arthritis	Leg Ulcer
Congestive Hrt Failure	Thyroid Disorder	Osteoarthritis	Transfusion
Carotid Artery Disease	Graves Disease	Rheumatoid Arthritis	Chemotherapy
High Cholesterol	Acid Reflux	Breast Cancer	Radiation Therapy
Stroke	GERD	Ovarian Cancer	History of Hepatitis
Poor Circulation	Hiatal Hernia	Uterine Cancer	HIV
Leg Cramps	Stomach Ulcer	Lung Cancer	**OTHER:**
Diabetes	Liver Disease	Prostate Cancer	

What kind of surgery have you had? (Circle all that apply) □ **(check) I HAVE NEVER HAD SURGERY**

Ankle Surgery	Fibroid Surgery	Gallbladder Surgery	Mastectomy
Appendectomy	Foot Surgery Bunion	Heart Valve Surgery	Ovarian Surgery
Adenoid	Foot Surgery Hammertoe	Heart Bypass Surgery	Prostate Surgery
Back Fusion	Foot Surgery (List):	Hip Replacement	Tonsillectomy
Back Disc Surgery	_____	Kidney Surgery	Gastric bypass
Brain Surgery	_____	Knee Arthroscopy	Cosmetic Surgery
Hysterectomy	_____	Knee Replacement	Other: _____

Please list all medication allergies: □ **(check) NO ALLERGIES TO MEDICATION**

Please list all of your medications:

How Tall Are You? **Ft** **in** **Weight** **lbs**

Do you Smoke? No Quit Yes Cigarettes a day Pack/Day How many years?

Do you drink alcohol? Beer / Wine / Hard Liquor How Much? /Day /Week

Family History (Circle all that apply. Mother / Father / Sibling:

Heart Disease M / F / S	Hammertoes M / F / S	Gout M / F / S
Stroke M / F / S	Diabetes M / F / S	Kidney Disease M / F / S
Circulation Problems M / F / S	Neurological Disorder M / F / S	Bleeding Problem M / F / S
Flat Feet M / F / S	Rheumatoid Arthritis M / F / S	
Bunions M / F / S	Osteoarthritis M / F / S	

What kind of exercise do you do and how often?

What type of job do you do? (Circle) Sit Stand Stands & Walks Retired Revised 07-2012