



PATIENT'S MEDICAL INFORMATION

Patient's Name: _____

Last Physical Exam: _____

Chief Foot Complaint? _____

How Long Have You Had This Condition? _____

Have You Had Previous Treatment? _____

1. Are you in good health? Yes No

Do you smoke? Yes No

2. Are you now or have you been under the care of a physician during the past two years? Yes No

3. Are you presently taking medication? Yes No

If yes, please list: _____

4. Are you subject to excessive bleeding? Yes No

5. Is there any personal or family history of diabetes? Yes No

6. Do you have any allergies? Yes No

If yes, please list: _____

7. Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever, kidney or liver involvement? Yes No

8. Have you had any serious illnesses or operations? Yes No

If yes, please list: _____

9. Please list your occupation: _____

10. Shoes most commonly worn: _____

I hereby give permission to Dr. Kathleen M. Stone or Dr. Teisha L. Chiarelli to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature _____ Date _____