

Heartland Foot & Ankle Associates, P.C.
Medical History

What is/are your foot problem(s):

How did you hear about our office? _____

Current Shoe Size: _____

Current Weight: _____ lbs

Height: _____

Have you ever worn custom made arch supports (orthotics) Yes No

Do you smoke? Yes No

Do you drink alcohol? Yes No

Illnesses: (Please check those which apply):

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Feet | |

Family History: (Please check those which apply):

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Feet | |

Allergies to Medications: (Please check those which apply):

- | | | | |
|---------------------------------------|----------------------------------|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Sea Food/Shellfish | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Other: _____ | | | |

Medications You are Currently Taking: (Both prescription and non-prescription)

Prior Surgery and/or Illnesses:

I hereby give my permission to the doctor(s) at Heartland Foot and Ankle Associates, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

PATIENT SIGNATURE: _____ **DATE:** _____