

MEDICAL HISTORY

Patient's Name	Date of Birth	Age	Today's Date	Case No. (office to assign)
Residence Address	City	State	Zip	Daytime Phone No.
Family Physician's Name	Address			Phone No.

My foot problem involves my Right Foot Left Foot Both Feet

Describe your foot problem: _____

	Yes	No	Please Explain
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any serious illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any major operations?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	
May we contact your Physician?	<input type="checkbox"/>	<input type="checkbox"/>	

What medications do you take regularly? _____

Mark (x) any of the following you have or have had problems with:

GENERAL MEDICAL HISTORY

- Diabetes
- Arthritis
- Circulation
- Gout
- Anemia
- Asthma
- Stomach Ulcers
- Hardening of Arteries
- Infection Prone
- Bleed Easy
- Slow Healer
- Heart Trouble
- Kidney Trouble
- Liver Trouble
- Fainting Spells
- High Blood Pressure
- Polio
- Rheumatic Fever
- Tuberculosis

- Cancer
- Epilepsy
- Gangrene
- Drug Allergies
- Other: _____

FOOT & LEG CONDITIONS

- Bunions
- Bone Fracture
- Bow Legs
- Burning
- Arch pain
- Foot Cramps
- Leg Cramps
- Unequal Leg Length
- Knee Pain
- Heel Pain
- Knocked Knees
- Sprains
- Weak Ankles

- Swelling
- Low Back Pain
- Varicose Veins
- Nerve Injury
- Stiffness
- Coldness
- Numbness
- Pigeon Toes
- Toes Outward
- Flat Feet
- High Arches
- Hammertoes
- Other: _____
- Other: _____

FOOT SKIN PROBLEMS

- Fungus
- Growth
- Hard Corns
- Soft Corns
- Dryness

- Calluses
- Moist Skin
- Other: _____
- Other: _____

TOENAIL PROBLEMS

- Fungus
- Thick
- Curved
- Ingrown
- Brittle
- Deformed
- Discolor
- Other: _____

SHOE WEAR PROBLEMS

- Tip
- Heel
- Upper
- Soles
- Other: _____
- Other: _____

Any additional information you wish us to know: I hereby give Dr. Kenneth Abram, D.P.M. permission to examine and treat my feet. Signature _____ Patient (Parent or guardian if minor)	Are you allergic or sensitive to:
	Yes No
	Novocaine
	Adhesive Tape
	Fabric
	Other
	If yes, what

Summary (Doctor's use):