

Please fill out all the following information:

Date _____

Name _____

Date of Birth _____

Signature _____

Sex Male Female

Occupation _____

Married Single Divorced Widowed

Do you have an advance directive or a living will?
 Yes No

Please indicate any religious, cultural, or spiritual values you wish to be considered in your health care treatment decision making:

Medications and Allergies

Please list all current medications. Please include all prescription and over the counter drugs as well as birth control pills, herbal medications, and vitamins.

Medication	Dosage/How Often
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Allergies	Reaction
_____	_____
_____	_____
_____	_____

Social History (circle yes or no)

DRUG/ALCOHOL USE		
Do you or have you ever smoked?	YES	NO
If yes, how many cigarettes a day?		
If former smoker, when did you quit?		
If former smoker, how long did you smoke?		
Do you drink alcohol?	YES	NO
Do you use illegal drugs?	YES	NO
Do you drink caffeine?	YES	NO
If yes, how much per day?		
Do you exercise?	YES	NO
If yes, what activity? CIRCLE Jogging, Running, Cycling, Spinning, Aerobics, Step, Tennis, Racquetball, Weights, Martial Arts, Other		
How many days per week?		
Time/duration (minutes)?		
Shoes and Inserts		
What is your shoe size?		
What brand of shoes do you wear for exercise?		
Do you wear inserts or orthotics?	YES	NO
If yes, are they custom-made for your foot?	YES	NO

Past Surgical History

Please check the box if you have had the surgery and then indicate the year if you know it.

SURGERY	Y	YEAR	SURGERY	Y	YEAR
Back Surgery			Joint		
Eyes			Hip		
Foot Trauma			Knee		
Heart Bypass			Other:		
Kidney Transplant			Foot & Ankle Surgery:		
Lower Extremity Bypass					

Children			
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Past Medical History

Please check if YOU have had any of the following:

AIDS		Heart Disease	
Alcoholism			
Alzheimer's		High Blood Pressure	
Anemia		High Cholesterol	
Anesthesia Complications		Joint Pain	
Anxiety		Kidney Disease	
Asthma		Kidney Stones	
Back Pain		Liver Disease	
Blood Disorder		Migraines	
Blood Clots		Osteoporosis	
Blood Transfusions		Pneumonia	
Cancer / Type:		Reflux (gastric)	
Dementia		Seasonal Allergies	
Depression		Seizures	
Diabetes		Sexually Transmitted Disease	
Emphysema		Stroke	
Eye Disease		Thyroid Disease	
Glaucoma		Other	

Hospitalizations:

Date (mo/year) Reason

/	
/	
/	
/	

Comments on Past Medical History: _____

Family History

Family Member	Age if Living	Age Deceased	Cause of Death
Mother			
Father			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Sibling			

Family History Continued

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

M=Mother F=Father B=Brother
S=Sister G=Grandparent

DISEASE/COND.	M	F	B	S	G
Alcoholism					
AIDS					
Alzheimer's					
Anemia					
Anesthesia Problems					
Anxiety					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer					
Type:					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Additional Comments on Family History: _____

History of Testing

Test	DATE		NORMAL RESULTS	ABNORMAL RESULTS
	MO.	YEAR		
Bone Density Scan				

Primary Care Physician/Provider: _____

Referring Physician/Provider: _____