HUGAR FOOT CLINIC
HISTORY

Name _____ Date _____

Height _____ Weight _____ Age _____ Sex _____ Shoe Size _____

Chief Complaint/HPI _____

_____

_____

Previous treatment & physician _____

GENERAL HEALTH Good _____ Fair _____ Poor _____

Do you have diabetes? Yes No Last blood sugar _____ Diabetes in family? Yes No

Do you have pain, cramps, swelling, tingling or numbness in your feet or legs? Yes No

Explain _____

Do you bruise easily? Yes No Do you have low back pain? Yes No

Current medications? Yes No List _____

_____

Do you smoke? Yes No Do you drink? Yes No

Past surgeries or hospitalizations _____

_____

WOMEN: Are you, to your knowledge, pregnant? Yes No

ALLERGIES/SENSITIVITIES

Penicillin	_____	Antibiotics	_____	Drugs	_____	Novacaine	_____
Adhesive Tapes	_____	Foods	_____	Anesthetics	_____	Codeine	_____
Iodine	_____	Aspirin	_____	Other/Explain	_____		

No Known Allergies _____

FAMILY HEALTH Have you or a family member ever had the following:

CONDITION	PATIENT	FAMILY	EXPLAIN
Heart trouble			
High Blood Pressure			
Kidney trouble			
Lung problems			
Asthma			
Stomach/Bowel problems			
Liver problems			
Circulatory problems			
Varicose veins			
Epilepsy			
Arthritis/Gout			
Cancer			
Rheumatic fever			
Bleeding problems			
Other Medical Conditions			

Podiatrist Comments: _____

_____

Date _____ *Signature* _____ *D.P.M.*