



## Medical History / Health Questionnaire

What problems are you having with your ankles / feet? Which foot or ankle? \_\_\_\_\_

Have you been treated for this condition before? Yes / No. By whom? \_\_\_\_\_

Please list your medications:

Name of Medicine	Used for what condition?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Do you have a family history of:  Diabetes,  Heart Disease,  Cancer,  Other \_\_\_\_\_

Do you have any of the following?

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Arthritis: _____      | <input type="checkbox"/> Infection (current): _____ |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Kidney Problem: _____      |
| <input type="checkbox"/> Bleeding disorders    | <input type="checkbox"/> Liver Problem: _____       |
| <input type="checkbox"/> Circulation disorders | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Cancer: _____         | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Diabetes. Type: _____ | <input type="checkbox"/> Stomach Ulcer              |
| <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Swelling: _____            |
| <input type="checkbox"/> Heart Problem: _____  | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Hepatitis A B C D E   | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> Other: _____               |

Are you allergic to any of the following?

- |   |
|---|
| <input type="checkbox"/> Anesthesia: _____        |
| <input type="checkbox"/> Antibiotic: _____        |
| <input type="checkbox"/> Anti-inflammatory: _____ |
| <input type="checkbox"/> Aspirin                  |
| <input type="checkbox"/> Codeine                  |
| <input type="checkbox"/> Medicine: _____          |
| <input type="checkbox"/> Tape                     |
| <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Other: _____             |

Is there anything that the doctor should know before or while treating your medical conditions that is not listed here? \_\_\_\_\_

I certify that this information is true and correct and that the physician is relying on this information for my well being and health. I give Dr. Warby permission to obtain my medical history necessary for treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_