

MEDICATIONS: Please list **ALL** medications you are currently taking

<u>Medication</u>	<u>Strength (Dosage)</u>	<u>How Often taken</u>	<u>Reason for Taking</u>
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Are you taking any blood thinners?	YES	NO
Are you taking any steroid medication (prednisone)?	YES	NO
Do you have any metal implants?	YES	NO

SOCIAL HISTORY

Occupation:

% of work day Spent standing or walking?

Use of Alcohol: Never Occasionally Weekly Daily

Smoking: No Previously but quit Yes, Packs per day?

Recreational/ Street Drug Use: Never Rarely Daily

Exercise, Sports, or Recreational Activities

FAMILY HISTORY

Please list all diseases/conditions common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems, (May refer to conditions listed under medical history on previous page)

Has anyone in your family had a similar foot problem? YES NO

if deceased, cause of death

Father:

Mother:

I state that the above medical information is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health, I understand it is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient/Parent or Guardian

Date