

### INITIAL PATIENT EVALUATION

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Allergies: Penicillin Tetracycline Codcine Demerol Sulfa Aspirin  
Iodine Anesthesia Tape Other(list) \_\_\_\_\_

Patient Meds:	Name	Reason for taking

Diabetes: Yes No                      Controlled by: Insulin Med.  
Last blood sugar test \_\_\_\_\_

#### Medical History

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Hypertension      | <input type="checkbox"/> Intestinal       | <input type="checkbox"/> Gout                    |
| <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Mitral Valve Pro* | <input type="checkbox"/> Kidney/Urinary   | <input type="checkbox"/> Sickle Cell             |
| <input type="checkbox"/> Phlebitis         | <input type="checkbox"/> Unusual Bleeding | <input type="checkbox"/> Neuromuscular           |
| <input type="checkbox"/> Poor Circulation  | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Disease: M.S. M.D. CMT. |
| <input type="checkbox"/> Stomach Ulcers    | <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Polio                   |
| <input type="checkbox"/> Scarlet Fever     | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Thyroid                 |

\*Is antibiotic required for dental/minor surgery? Yes No

List: Major Surgery/Injuries/Fractures/Hip or Knee Replacements

\_\_\_\_\_

Other pertinent medical information: \_\_\_\_\_

\_\_\_\_\_

General Activities: \_\_\_\_\_

\_\_\_\_\_

Foot Complaint: \_\_\_\_\_