

YES	NO	NATURE OF PROBLEM	COMMENTS, GIVE DATE
		ALLERGIC REACTION TO MEDICATION	
		KIDNEY DISEASE OR STONES	
		JOINT PAIN OR STIFFNESS	
		NUMBNESS OR CRAMPS IN FEET OR LEGS	
		LOW BACK PAIN	
		DO YOU SMOKE ? HOW MUCH ?	
		DO YOU DRINK ALCOHOL ? HOW MUCH ?	
		DO YOU TAKE ANY DRUGS ? (LEGAL OR ILLEGAL)	
		DEPRESSION / PSYCHIATRIC	
		FAINING OR CONVULSIONS	
		STROKES	
		PAIN IN OTHER AREAS	
		HIV OR / OTHER ILLNESS OR PROBLEMS	

6. PLEASE GIVE DETAILS OF ANY :

	APPROXIMATE DATE	SURGEON / DOCTOR / HOSP
OPERATIONS		
SERIOUS INJURIES		
PHYSICAL THERAPY		
SEVERE INJURIES		

7. PLEASE INFORM US OF ANY OTHER IMPORTANT INFORMATION.

8. IS THERE ANYTHING YOU WISH TO TELL YOUR PHYSICIAN PRIVATELY ? YES ____ NO ____

9. SHOE SIZE _____ WEIGHT _____ HEIGHT _____

10. CIRCLE SPORTS IN WHICH YOU ARE INVOLVED : WALKING / JOGGING / BOWLING / TENNIS
HIKING / GOLF / OTHER _____

11. NUMBER OF HOURS ON FEET PER DAY _____

PATIENT'S SIGNATURE _____ DATE _____