MEDICAL INFORMATION SHEET

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:
NOVACAINE (YES/NO) PENICILLIN (YES/NO) CODEINE (YES/NO)
OTHER MEDICATIONS _____

ARE YOU ON BLOOD THINNERS? YES NO
(COUMADIN, PLAVIX, ASPIRIN, ETC.)

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS

ARE YOU BEING TREATED FOR OR HAVE YOU EVER HAD:

(1) ANEMIA	YES	NO
(2) CANCER (TYPE _____)	YES	NO
(3) CIRCULATION PROBLEMS	YES	NO
(4) DIABETES (TYPE _____)	YES	NO
(5) HEART DISEASE (SPECIFY _____)	YES	NO
(6) HIV/HEPATITIS	YES	NO
(7) HIGH BLOOD PRESSURE	YES	NO
(8) STROKE (TIA)	YES	NO

HAVE YOU HAD ANY FOOT SURGERIES? YES NO
(SPECIFY: BUNION / HAMMERTOE /
NEUROMA / AMPUTATIONS /OTHER _____)

HAVE YOU HAD ANY JOINT REPLACEMENTS? YES NO
(SPECIFY: HIP / KNEE / SHOULDER /OTHER _____)

HAVE YOU HAD VASCULAR/ HEART SURGERY? YES NO
PACEMAKER OR DEFIBRILLATOR ? _____

DO YOU SMOKE CIGARETTES ? YES NO

PRIMARY PHYSICIAN'S N AME: _____
DATE LAST SEEN: _____
SIGN NAME _____ DATE _____