NAME: _____DOB_____AGE_____ (CIRCLE) MALE FEMALE

MEDICAL HISTORY **PLEASE CHECK ALL THAT APPLY**

ALLERGIES TO ANESTHETICS	[ ]	EAR PROBLEMS	[ ]	PSYCHIATRIC CARE	[ ]
ALLERGIES TO MEDS OR DRUGS	[ ]	EPILEPSY	[ ]	RADIATION TREATMENT	[ ]
ANEMIA	[ ]	EYE PROBLEMS	[ ]	RASHES	[ ]
ANGINA	[ ]	FAINTING	[ ]	RESPIRATORY DISEASE	[ ]
ARTHRITIS	[ ]	FOOT/LEG CRAMPS	[ ]	RHEUMATIC FEVER	[ ]
ARTIFICIAL HEART/VALVES/JTS.	[ ]	HEADACHES	[ ]	SHORTNESS OF BREATH	[ ]
ASTHMA	[ ]	HEART DISEASE	[ ]	SINUS PROBLEMS	[ ]
BACK PROBLEMS	[ ]	HIV	[ ]	SPECIAL DIET	[ ]
BLEEDING DISORDERS	[ ]	HEPATITIS/JAUNDICE	[ ]	STROKE	[ ]
CANCER	[ ]	HIGH BLOOD PRESSURE	[ ]	SWELLING ANKLE/FEET	[ ]
CHEMICAL DEPENDENCY	[ ]	KIDNEY PROBLEMS	[ ]	SWOLLEN NECK/GLANDS	[ ]
CIRCULATION PROBLEMS	[ ]	LIVER DISEASE	[ ]	TIRED FEET	[ ]
CHRONIC DIARRHEA	[ ]	NERVOUS CONDITIONS	[ ]	TUBERCULOSIS	[ ]
DIABETIES	[ ]	PHLEBITIS	[ ]	ULCERS	[ ]

ALLERGIES (PLEASE CIRCLE ALL THAT APPLY)

ADHESIVE/TAPE IODINE ASPIRIN ANESTHETICS LATEX PENICILLIN CODEINE DEMEROL SULFER

FAMILY HISTORY OF DIABETIES CIGARETTE/TOBACCO USE

SURGERIES/HOSPITALIZATIONS_____

MEDICATIONS YOU ARE TAKING_____

_____

CONSENT

I CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO DR. ROBERT A. IRWIN TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND OR TREATMENT OF MY FOOT PROBLEMS.

X _____ _____

PATIENT/GUARDIAN/INSURED SIGNATURE DATE

ROBERT A. IRWIN, D.P.M,PC