Dr. Sean Lehmann, DPM		**Medical Health Questions**	**Date:_____**
Name : First	Middle	Last	
Address:	City:	Prov:	Postal Code:
Birth Date:	Phone #:	Care Card #:	
Height : Weight:	Shoe Size :	Name of Physician :	
Were you referred by your family physician for todays visit?			
Did your family physician give you a referral slip?			
Have you been hospitalized in the past 2 years?	When and Why?		

Do you wear orthotics? How long have you had them?

DESCRIBE YOUR FOOT PROBLEM(S) :

List your foot problems:	RIGHT FOOT	LEFT FOOT
Where ? (location on foot)		
How Painful? (circle one)	Mild Moderate Severe	Mild Moderate Severe
How long? (days, weeks, months)		
What have you done for treatment?		

MEDICAL HISTORY:

Check any of the following if you have or have had a problem with :

Heart		Circulation		Arthritis		Cancer		Bladder	
Asthma		Stomach Ulcers		Hormones		High Blood Pressure		Healing	
Anemia		Liver		Hepatitis		Skin Conditions		Kidneys	
Skin Ulcers		Gout		Tuberculosis		Depression		Venereal Disease	
Lungs		Diabetes		Weight Loss		HIV (aids)		FIBROMIALGIA	

DO YOU HAVE ANY?

Heart valve implant	Yes	No	Artificial joints	Yes	No
Mitral Valve Prolapse	Yes	No	Any history of Rheumatic Fever	Yes	No
Are you on a blood thinner	Yes	No	Other		

ARE YOU SENSITIVE, HAVE REACTIONS OR ARE ALLERGIC TO ANY OF THE FOLLOWING:

Local anesthetics like Novacaine Sulfa Codeine Aspirin Other:

Iodine Penicillin Demerol Tape

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE NOW TAKING :

Smoke? I do Used to No Occupation:

Diabetes? Yes No Briefly describe your work :

How often are you on your feet? Some of the time All of the time Rarely Most of the time