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MEDICAL INFORMATION

HOW IS YOUR GENERAL HEALTH? POOR _____ FAIR _____ GOOD _____

ARE YOU NOW OR HAVE YOU BEEN UNDER A DOCTOR'S CARE OR HAD ANY OPERATIONS DURING THE PAST TWO YEARS? YES NO

ARE YOU SUBJECT TO PROLONGED BLEEDING? YES NO

ARE YOU TAKING ANY MEDICATION AT THE PRESENT TIME? YES NO

IF SO, WHAT? _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (Circle)

DIABETES	YES	NO	DIFFICULTY IN HEALING	YES	NO
STOMACH ULCER	YES	NO	EPILEPSY	YES	NO
RHEUMATIC FEVER	YES	NO	TUBERCULOSIS	YES	NO
SHORTNESS OF BREATH	YES	NO	KIDNEY PROBLEMS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	LIVER PROBLEMS	YES	NO
GOUT	YES	NO	ANEMIA	YES	NO
ANY HEART PROBLEMS	YES	NO			

HAVE YOU EVER EXPERIENCED ANY ILL EFFECTS OR REACTIONS FROM:

**PENICILLIN _____ CODEINE _____ ASPIRIN _____ SULFA DRUGS _____ CORTISONE _____
NOVACAINE _____ TAPE _____ ANY ANTIBIOTICS _____**

DO YOUR FEET AND LEGS CRAMP, FATIGUE, OR STRAIN EASILY? YES NO

DO YOUR ANKLES TURN OR SPRAIN EASILY? YES NO

ARE THE BACK OR BOTTOM OF YOUR HEELS PAINFUL? YES NO

DO YOU SPEND MORE THAN 30% OF YOUR TIME AT WORK ON YOUR FEET? YES NO

DO YOU HAVE TO LIMIT YOUR ACTIVITIES BECAUSE YOUR FEET HURT ? YES NO

WHAT CURRENTLY BOTHERS YOU MOST ABOUT YOUR FEET? _____

IT HAS TROUBLED ME FOR: WEEKS _____ MONTHS _____ YEARS _____

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered to the best of my ability. If I am uncertain about any question on this form, I will ask the doctor or office staff for assistance.

SIGNATURE _____ DATE _____