



PERRY H. JULIEN, DPM
CHARLES F. PEEBLES, DPM

NAME _____ AGE _____ DATE _____
PLACE OF BIRTH: _____ DATE OF BIRTH _____

LOWER EXTREMITY PROBLEM: _____

DATE OF ONSET: _____
PREVIOUS TREATMENT: _____

PERSONAL HEALTH: Have you ever had any of the following (Please Mark):

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer - Tumors | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Deformities | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ulcers (Stomach) |
| Other _____ | | |

MEDICATIONS: (Please list ALL including non-prescription medications)

NAME	REASON FOR TAKING	DATE STARTED
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> ASPIRIN |
| <input type="checkbox"/> SULFA | <input type="checkbox"/> IODINE |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> DEMEROL |
| <input type="checkbox"/> ADHESIVE TAPE | |
| <input type="checkbox"/> OTHER _____ | |

DO YOU SMOKE?

No ___ Yes ___ Packs
Number of Years _____

DO YOU DRINK ALCOHOL?

Yes _____ No _____
_____ Drinks/Week

FAMILY MEDICAL PROBLEMS _____

SURGICAL/HOSPITALIZATION HISTORY:

Type of Surgery/Reason for Hospitalization	Hospital	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICAL ACTIVITY

- | | | |
|--------------------|-----------------|--|
| Walking | Frequency _____ | <input type="checkbox"/> NO REGULAR EXERCISE |
| Jogging/Running | _____ | |
| Cycling/Spinning | _____ | |
| Aerobic Dance/Step | _____ | |
| Tennis/Racquetball | _____ | |
| Weight Training | _____ | |
| Other _____ | _____ | |

PLEASE INDICATE IF THERE IS ANY ADDITIONAL INFORMATION YOU WOULD LIKE DR. JULIEN OR DR. PEEBLES TO KNOW: _____