# PATIENT HEALTH INFORMATION

**Patient Name**:_____ **D.O.B.:**_____

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**Shoe Size**:_____

**Activity Level (circle)**: Minimal Moderate High

**Sports**:_____

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**Medication(s)**: (Use back of page if more room needed)

Name: _____ Dose:_____ Frequency:_____

Name: _____ Dose:_____ Frequency:_____

Name: _____ Dose:_____ Frequency:_____

Name: _____ Dose:_____ Frequency:_____

Name: _____ Dose:_____ Frequency:_____

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**Allergies**:_____

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**Illness**: ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Kidney ☐ Lung ☐ PVD

☐ Arthritis ☐ Cancer ☐ Heartburn ☐ Headache ☐ Stroke Other:_____

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**Surgeries**:_____

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**Smoker (circle)**: Yes / No **Drink Alcohol**: Yes / No

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**Today's Complaint**: _____

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**Additional Info**: _____

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