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PATIENT MEDICAL HISTORY REQUEST

Patient Name:_____Patient Age:_____

Length of time suffering from the onset of _____ months or years (circle one)

___Chronic Proximal Plantar Fascitis
___Chronic Lateral Epicondylitis

Other Dx_____

I have tried the following conservative treatments without relief: (check all that apply)

__Cortisone Injections __Physical Therapy __Stretching
__Foot Supports (Orthotics) __Night Splints __NSAIDS
__Changes in foot gear __Other_____

Please provide a medical history of your condition with how it affects your personal life and your work, i.e. can no longer exercise, unable to stand for long periods of time and job requires standing. Please list all types of treatments, medication, or devices, prescribed and not prescribed, that you have tried for your condition. Please try to include dates. Have any of the treatments helped with your symptoms in any way?

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Signature of Patient Date