PATIENT MEDICAL HISTORY

What is your main foot or ankle complaint that you would like the doctor to address today?

_____
How long has this been a problem? __ days __ weeks __ months __ years.
Have you had any prior treatment __ yes __ no; If so, what: _____
Height _____ Weight _____ Shoe size _____
Any family history of: ___Diabetes ___ Flat feet ___ Bunions ___ Hammertoes ___ Fungus
What is your Physician's name_____ Last exam _____
List any medicines or substances you are allergic to and your reaction:
Name: _____ Reaction_____
Name: _____ Reaction _____
Name: _____ Reaction _____

Please list all prescription and over the counter medicines you are currently taking: _____
_____
_____
_____
Pharmacy used: _____

Do you smoke? __ yes __no; if so for how long? _____.
Alcohol: what type_____ Amount_____ How often _____.

Prior hospitalizations and surgeries:

(Month/Year)	(Condition)	(Month/Year)	(Condition)
_____		_____	
_____		_____	
_____		_____	

Are you currently or have you been treated for any of the following:

___ Anemia
___ Arthritis
___ Asthma
___ Artificial joint
___ Back/Neck pain (circle one)
___ Blood clotting abnormality
___ Cancer: Type _____
___ Diabetes: How long _____
___ Deep vein thrombosis
___ Depression
___ Emphysema
___ Epilepsy/seizures
___ Fibromyalgia
___ Gastric reflux
___ Glaucoma
___ Gout
___ Heart disease/ failure
___ Hepatitis/cirrhosis
___ High blood pressure
___ HIV/AIDS
___ Kidney disease/dialysis
___ Neuropathy
___ Pacemaker
___ Phlebitis
___ Psychiatric care
___ Rheumatic fever
___ Stroke
___ swollen legs/feet
___ Thyroid disease
___ Ulcer
___ Venous stasis
Other _____
Other _____

FAMILY HISTORY
Any family history of: ___ Diabetes ___ Heart problems___ Stroke ___ High blood pressure ___ Cancer

THANK YOU FOR FILING OUT THIS FORM. IT WILL HELP US GIVE YOU THE BEST PODIATRIC MEDICAL CARE.