

Date: \_\_\_\_\_ **PATIENT MEDICAL HISTORY** Date of birth \_\_\_\_\_

Medical doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ CELL \_\_\_\_\_

PLEASE DESCRIBE THE FOOT OR ANKLE PROBLEM THAT BROUGHT YOU TO OUR OFFICE TODAY: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had this problem before: YES \_\_\_\_\_ NO \_\_\_\_\_  
Have you ever seen a podiatrist before for any problem YES \_\_\_\_\_ NO \_\_\_\_\_  
If YES, please describe \_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes			Abnormal bleeding problem		
Any heart problem			Stomach ulcers		
Abnormal blood pressure			Asthma		
Arthritis			Seizures or epilepsy		
Kidney disease			Difficulty in healing		
Lung disease			Hepatitis		
Gout			Cancer		
Thyroid disease			Liver disease		

PLEASE DESCRIBE ANY MEDICAL PROBLEMS NOT MENTIONED ABOVE: \_\_\_\_\_  
\_\_\_\_\_

PLEASE DESCRIBE ANY HOSPITALIZATIONS OR SURGERY: \_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING: \_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO THE FOLLOWING:

	YES	NO		YES	NO
Shellfish			Novocaine		
Codine			Aspirin		
Sulfa			Adhesive tape		
Penicillin			ANY OTHER		

Is there a family history of: Diabetes \_\_\_\_\_ Heart disease \_\_\_\_\_ Blood clots \_\_\_\_\_ Stroke \_\_\_\_\_  
Cancer \_\_\_\_\_ Gout \_\_\_\_\_ IF YES, WHICH FAMILY MEMBER \_\_\_\_\_

Do you smoke \_\_\_\_\_ Do you drink alcohol \_\_\_\_\_  
Does your work or lifestyle involve spending large amounts of time on your feet? \_\_\_\_\_

Do you exercise \_\_\_\_\_ If yes, how much \_\_\_\_\_  
In case of emergency, notify: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_