Medical History

1. **Do you have or have you had any of the following conditions?**

	Yes	No		Yes	No
Diabetes			Organ Transplant		
Asthma			Heart Disease		
Rheumatic Fever			Chest Pain		
Hepatitis			Pneumonia		
Glaucoma			Kidney Disease		
Seizures			Cancer		
High Blood Pressure			Stroke		
Artificial Joint/Valve			Emphysema		
Immunosuppression					

Other_____

2. **List any past illness or surgery for which you were hospitalized.**
Operation/Illness_____ Year_____
_____
_____

3. **List and describe any allergies to medications and other substances.**
_____
_____
_____

4. **List any current medications (include prescription and non-prescription drugs)**
Medication Dosage
_____
_____
_____

5. **Do you use Tobacco? Yes No If yes, how much?** _____
6. **Do you use alcohol? Yes No If yes, how much?** _____
7. **Have you received a blood transfusion? Yes No**
If yes, when? _____
8. **Have you had a recent weight loss? Yes No**
If yes, how much? _____
9. **What is the reason for today's visit?** _____

Central Connecticut Foot Care Center, LLC

Print name of patient:_____

Relationship to Patient:_____
Example: self, mother, father, legal guardian, other (specify)

Do you give our office permission to discuss your medical information with family Members? Yes No

If yes, please provide us with names and phone numbers below:

_____
Name/relationship phone number

_____
Name/relationship phone number

May we leave personal medical information on your:

Answering Machine? Yes No

Cell Phone voice mail? Yes No

May we e-mail personal medical information to you? Yes No

E-Mailaddress:_____

My signature below indicates I have received and/or reviewed a copy of the Privacy Practice Policy of this office and have agreed to the release of my health information as indicated above.

_____
Patient or Responsible Party Signature Date