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 MENIONED 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*		
Codiene			*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 _____