PATIENT HEALTH RECORD

What is your present foot problem(s)?____

How long have you been bothered by the above?____

What have you done for your foot problem?____

Medical History (This confidential information helps us determine proper treatment and medication)

Physician's Name________________________________ **Phone**________________

Physician's Address____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING: **Check all that apply to you**

AIDS/HIV infection	___	Hepatitis/Jaundice	___
Anemia	___	Herpes	___
Artificial heart valves	___	High/low blood pressure	___
Artificial joints/implants	___	Hives or skin rashes	___
Asthma	___	Kidney disease	___
Back or neck problems	___	Liver disease	___
Bruise or bleed easily	___	Pacemaker	___
Bulimia or anorexia	___	Psychiatric treatment	___
Cancer/tumor	___	Rheumatic fever	___
Chemical dependency	___	Seizures	___
Chest pain	___	Scarlet fever	___
Cortisone treatment	___	Shortness of breath	___
Diabetes	___	Sickle cell anemia	___
Epilepsy/or neurological problems	___	Stomach ulcers	___
Fainting or dizzy spells	___	Stroke	___
Glaucoma	___	Phlebitis	___
Heart disease	___	Thyroid disease	___
Mitral valve prolapse	___	Tuberculosis	___
Heart murmur	___	Ulcers	___
Gout	___		

Do you have any disease, condition, or problem not previously listed? ____________________
Are you allergic to Penicillin___ Codeine___ Local anesthetics___ Latex___ Other____________________
Are you under the care of a physician and why? ____________________
Have you been treated in a hospital in the past 2years? ____________________
Please list all prescription drugs you are now taking (please include any herbal or over-the-counter medication)

____

Do you take vitamins regularly? If so, please list ____________________
Has you physician advised you to premedicate before dental treatment? ____________________
If female: Are you taking hormones or birth control?________ Are you pregnant or nursing________
Have you ever had a blood test for hepatitis? ________ Have you been vaccinated? ________
Do you use tobacco? ________ Have you had a recent weight loss/gain? ________ Do you use alcohol? ________

Have you had surgery? ________ If so, what type? ____________________ Year ______
Type ____________________ Year ______

FAMILY HISTORY
Circle if any blood relatives have had: Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Overweight

I HEREBY GIVE PERMISSION TO THE DOCTORES TO EXAMINE, DIAGNOSE AND TREAT MY FEET MEDICALLY, OR SURGICALLY AND ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Patient (parent/guardian) Signature: ______________________________ Date:____________________