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Medical History

	Yes	No
AIDS/HIV		
Anemia		
Arthritis, Where? RA, OA, Gout?		
Asthma		
Back Problems		
Bleeding Disorders, Explain:		
Cancer, Explain:		
Circulation Problems, Explain:		
Diabetes, Type 1, Type 2		
Foot or Leg Cramps, Explain:		
Gastric Intestinal Problems, Colitis, Crohn's, Gastritis, GI Bleeding, Ulcers, Other		
Heart Condition? Heart Attack? Disease? Murmur?		
Hepatitis, Jaundice, Liver Conditions		
High Blood Pressure		
Phlebitis? Deep Vein Thrombosis?		
Swollen Ankles? Feet?		
Tuberculosis		
Veneral Disease		
Are you Pregnant or Nursing?		

Please list any Medications you are CURRENTLY taking:

Have you EVER had any Surgery? EXPLAIN:

Family History (M) Mother (F) Father

Arthritis ___ Cancer ___ Diabetes ___ Heart Problems ___ Muscule Disorders ___
 Neurological Disorders ___ Other Conditions _____

Social History

	Yes	No
Do you drink Alcohol? How much? Occasionally		
Do you Smoke/Tobacco? How many packs/cigerattes per day:		
Do you take recreational drugs?		

I have completed this form to the best of my ability:

_____ Patient/Guardian

_____ Date