ACCESS FOOT SPECIALISTS PODIATRY CLINIC

Patient Medical Questionnaire

Name__________________________________________ Date___________________

Reason for Visit__________________________________________________________

Present Patient Medical Problems__________________________________________

Family History of Cancer: Circle : YES or NO and if yes please explain_________

______________________________________________________________________

Medications currently taking AND Allergies_________________________________

______________________________________________________________________

Have you ever had surgery? If yes, please list type of surgery and date that it was performed_____________________________________________________________

Have you ever been hospitalized? If yes, specify the reason for hospitalization and approximate dates_______________________________________________________

Please **check** all medical problems listed that you have had past or present:

History of Back Pain____________Heart Disease_____ Diabetes____

High Blood Pressure____________Skin Disease_______ Arthritis____

Stomach Ulcers__________Kidney Disease____Liver Disease______

Bone or Joint Disease_____

Patient Email Address_____________________________________________________

Signature________________________________________Date___________________

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy, have viewed an electronic copy, or that I can request a copy in the medical office of the Notice of Privacy Practices. I acknowledge that I have read and understood the notice.

Printed Name:_________________________________________________________

Signature:_______________________________________Date____________________