Medical Information

Patient Name: _____ DOB: _____Date: _____

Height: _____ Weight: _____ Shoe Size: _____ Width: _____

What is the Foot or Ankle Problem that brings you to our office? (Please be specific):

_____

_____

Pharmacy Name: _____ City: _____ Ph#_____

Family Doctor: _____City: _____ Last Visit:_____

Previous Podiatric Doctor: _____ City: _____Last Visit: _____

Medications

Include prescriptions, over the counter meds and vitamins:

❑ *See Attached List*

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____
6. _____ Dose: _____
7. _____ Dose: _____
8. _____ Dose: _____

Allergies

- ❑ Antibiotics: _____
- ❑ Penicillin
- ❑ Iodine
- ❑ Sulfa
- ❑ Codeine
- ❑ Adhesive Tape
- ❑ Latex
- ❑ Other: _____

_____

❑ ***NO KNOWN ALLERGIES***

Family History

	Mother	Father
• Deceased	❑	❑
• Cancer	❑	❑
• Stroke	❑	❑
• Blood Pressure	❑	❑
• Diabetes	❑	❑
• Heart Problems	❑	❑
• Foot Problems	❑	❑
• Other: _____	❑	❑

Surgical History

Please include same day surgery & childbirth:

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Reason:_____Date_____

Recreational Habits

- ❑ Prior or Current Alcohol/Drug Problem
- ❑ Caffeine _____drinks/day
- ❑ Alcohol _____drinks/day
- ❑ Tobacco: □ Cigarettes □ Chew _____pack(s)/day

Tobacco Year Began: _____

Tobacco Quit Date: _____

Medical Conditions

❑ Arthritis	❑Stomach Problems	❑Blood Disease
❑ Asthma	❑ Shortness of Breath	❑Liver Trouble
❑ Diabetes	❑ Blood Clots/Embolism	❑Slow Healing
❑ Cancer	❑ High Blood Pressure	❑Stroke
❑ Thyroid	❑ Tuberculosis	❑AIDS/HIV
❑ Anemia	❑ Kidney Trouble	
❑ Gout	❑Heart Trouble	