Medical Information

→ Patient Name:		D	OB:	Date:	
✦Height:	Weight:	Shoe Size:		Width:	
♦ What is the Foot or	Ankle Problem that bring	s you to our	office? (Please	be specific):	
→ Pharmacy Name:			_ City:	Ph#	
→ Family Doctor:		City: _	·	🗖 NO FAMIL	Y DOCTOR
→ Previous Podiatric Doctor:		C	City:Last Visit:		
<u>Medications</u>			<u>Allergies</u>		
Include prescriptions, over the counter meds and vitamins: 1			□ Antibiotics: Penicillin □ lodine □ Sulfa □ Codeine □ Adhesive Tape □ Latex □ Other:		
<u>Family History</u>			Surgical History		
 Deceased Cancer Stroke Blood Pressure Diabetes Heart Problems Foot Problems Other: Adopted (unknown Parents are Alive 8 			Reason: Reason: Reason: Reason: Reason:		te
Recreational Habits □ Prior or Current Alcohol/Drug Problem □ Caffeine			☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Anemia ☐ Gout	Medical Conditions □ Stomach Problems □ Shortness of Breath □ Blood Clots/Embolism □ High Blood Pressure □ Tuberculosis □ Kidney Trouble: □ Heart Trouble:	□Blood Disease □Liver Trouble □Slow Healing □Stroke □AIDS/HIV
			☐ NO MEDICAL CONDITIONS		