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: __________________ ❒ **NO FAMILY DOCTOR**

➔Previous Podiatric Doctor: ______________________City: _____________Last Visit: _______________

Medications

Include prescriptions, over the counter meds and vitamins:

1. ________________________ Dose: __________
2. ________________________ Dose: __________
3. ________________________ Dose: __________
4. ________________________ Dose: __________
5. ________________________ Dose: __________
6. ________________________ Dose: __________

❒ ***See Attached List***

❒ **NO MEDICATIONS TAKEN**

Allergies

	REACTION:
❑ Penicillin	_____________________
❑ Iodine	_____________________
❑ Sulfa	_____________________
❑ Codeine	_____________________
❑ Adhesive Tape	_____________________
❑ Latex	_____________________
❑ *Other:*	_____________________
Reaction:	_____________________

❑ **NO KNOWN ALLERGIES**

Family History

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

❒ Adopted (unknown history)

❒ Parents are Alive & well: No Medical Complications

Surgical History

Please include same day surgery & C-sections:

Reason:_____________________Date____________

Reason:_____________________Date____________

Reason:_____________________Date____________

Reason:_____________________Date____________

Reason:_____________________Date____________

Reason:_____________________Date____________

❒ **NO SURGERIES DONE**

Recreational Habits

❑ Alcohol: ❑Beer ❑Wine ❑Liquor

❑ Consumption: ❑Social ❑Occasional ❑Light ❑Heavy

❑ Tobacco: ❑Cigarettes ❑Chew _________pack(s)/day

Tobacco Year Began: ______________________

Tobacco Quit Date: _______________________

❒ **NONE OF THE ABOVE USED**

Medical Conditions

❑ Diabetes Type I	❑ High Blood Pressure
❑ Diabetes Type II	❑ Blood Clots/Embolism
❑ Arthritis	❑ Heart: _______________
❑ Asthma	❑ Kidney: ______________
❑ Thyroid	❑ Cancer: ______________
❑ Anemia	❑ Stomach: _____________
❑ Gout	❑ Blood Disease: ________
❑ Stroke	❑ Other: _______________
❑AIDS/HIV	_____________________