Medical History

Are you allergic to:

Morphine ___
Penicillin ___
Sulfa Drugs ___
Codeine ___
Aspirin ___
Mycins ___
Local Anesthetics (Novocain, etc.) _____

Any other drugs? Please list: _____

_____

_____

_____

Do you now have or have you ever had?
(please check if yes)

Rheumatic Fever ___
Kidney Disease ___
Liver Disease ___
Arthritis ___
Varicose Veins ___
Heart Disease ___
Blood Clots ___
High Blood Pressure ___
AIDS ___
Depression ___

Gout ___
Anemia ___
Diabetes ___
Strokes ___
Asthma ___
Tumors ___
Ulcers ___
HIV ___
Anxiety ___

Are you pregnant or nursing? Yes No

Other: _____

_____

Please list Medications you are taking: _____

_____

Surgeries (please list): _____

_____

Briefly describe your current foot problems: _____

_____

I hereby give my permission for Dr. Coates to examine, consult, and treat my feet medically, surgically, or biomechanically.

SIGNATURE: _____ Date: _____