

Patients Medical History

Patient Name: _____ **Age** _____ **Male/Female**

Describe your foot problem: _____

Is your problem related to an injury from: Work Auto Accident Other _____

If this is an accident, please list your date of injury: _____

Medical Doctors Name: _____ Date of last visit: _____

Are you **ALLERGIC** to any of the following? Please circle all that apply.

Local anesthetic General anesthetic Codeine Asprin Tape **No known allergies**

Penicillin Sulfa Drugs Iodine Shellfish Hayfever

List any other allergies you may have: _____

List **ALL** medications and vitamins: (Name, Dosage, Frequency) List **ALL** Surgeries/Hospitalizations: (Operation/Date)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have or have you had any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Eye Problems/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>

List any other medical conditions: _____

Do you smoke? No Yes I Quit. When _____ How many packs a day? _____ How many years? _____

Do you drink alcohol? No Yes Type? _____ How much? _____ How often? _____

Have you used recreation drugs? No Yes What kind? _____

Do you exercise regularly? Yes No What kind? _____ How often? _____

Do you know of any significant medical problems that run in your family? (such as high blood pressure, diabetes, heart Problems, cancers, ect.) Please list family member and the problem.

Father (age) (____): _____ Mother (age) (____): _____

Grandparents: _____

Siblings: _____

Children list male or female, ages and any medical problems: _____

Other members of your family with FOOT problems: _____

Is there anything else you feel the doctor needs to know about that we did not ask you on this form?

Signature of Patient or Parent/Guardian if Minor

Date
