

Medical & Podiatric History

Please complete the following information which will assist in determining an accurate diagnosis and proper course of treatment.

Patient's Name	Date of Birth	Age	Date of Last Physical Exam	By Whom
List Medical Conditions For Which You Are Currently Being Treated	Current Medications		Current Primary Care Physician & City	
			Other Current Medical Specialists & City	

Previous Surgeries / Hospitalizations: Year & Reason _____ _____ _____ _____ _____ _____ _____ _____	Are You Allergic or Sensitive to: <input type="checkbox"/> Novocaine <input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Iodine <input type="checkbox"/> Foods <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Medications Are You a Smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes How Many Years _____ Packs/Day _____ Do You Consume Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Amount/Week _____ Do You Drink Coffee? <input type="checkbox"/> No <input type="checkbox"/> Yes Cups/Day _____
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Please check (✓) any of the following conditions you have had.

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sudden Weight Change	<input type="checkbox"/> Polio
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Cirulation Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Acquired Immune Deficiency Syndrome
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Hardening of the Arteries	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Other _____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Anemia	<input type="checkbox"/> Neurological Problems	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Previous Trauma or Fractures (List year and injury) _____			

Family History: (If deceased list cause of death)		If you have children, please complete:		
	Age	Health Problems	Age	Sex Health Problems
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Reason for Visit	Please briefly describe your foot, ankle or leg problems. (Include which foot, R, L, or both; how long the problem has existed, and any previous treatment.)
1.	_____

2.	_____

3.	_____

4.	_____
