MEDICAL HISTORY

Patient Name:_____

It is a pleasure to welcome you to our office! In order to best serve your podiatric medical/surgical needs, please take a moment to complete this medical history form.

Are you in good health?_____
Are you now or have you been under a Physician's care during the past year?_____
If so, for what medical problem?_____
Pharmacy Name and Location_____
Pharmacy Phone Number_____
Do you have a family physician? No If Yes; Last time seen_____

Physician's Name_____ Phone Number_____

Are you being treated by any specialty physicians? Yes No

Physician's Name_____ Phone Number_____

Are you currently taking any medications? Yes No If so, please list medication dosage

Name of Medication	Dosage/Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Daily vitamins_____ Daily Aspirin_____

Do you have any allergies or have you ever had a negative reaction to Penicillin, Sulfa, Codeine, Aspirin, Iodine, Novocain, metals, shellfish, adhesive tape, local anesthetics, pollen, mold, dust, materials, foot, topical contactants, animals, soap, clothing, jewelry, cosmetics or anything else?_____
_____
_____

Please circle if you have ever been treated for any of the following conditions: **Heart disease, Gout, High Blood Pressure, Diabetes, Blood Clot, Rheumatic Fever, TB, Cancer, Thyroid, Ulcers, Hepatitis, Asthma, Epilepsy, Stroke, Anemia, Phlebitis, Arthritis, AIDS, Depression, Bronchitis, Anxiety, Heart Murmur, Syphilis, Gonorrhea, Sickle Cell, Broken Bones, Prolonged bleeding, Bowel, Bladder, Kidney, Liver or Lung Problems, or any other medical concern?**_____
_____

Have you ever been hospitalized for an illness, injury or have you ever had any surgery? If so please list:
_____
_____

Do you have a family history of any of the following health disorders? **Heart Disease, Diabetes, High Blood Pressure, Cancer, Sickle Cell Anemia, Other:**_____
_____
_____

Patient's Name: _____

Do you smoke? ◯Never ◯Current ◯Former If yes, how much?_____ How long?_____
Do you drink the following beverages?

Coffee:	Frequently	Occasionally	Never

Soda: Frequently Occasionally Never
Alcohol: Frequently Occasionally Never

Do you take birth control pills?_____ How long?_____
Are you now or is there a possibility that you are pregnant?_____
Are you breast feeding?_____

Do you take any recreational drugs?_____

Have you ever been treated for or diagnosed with AIDS or HIV carrier?_____

Do you heal well?_____
Do you tend to bruise or scar easily?_____

Are you currently involved in a sport or exercise program on a regular basis?_____

What kind of shoes do you wear the most?_____
What is your shoe size?_____ Width?_____

What is your weight?_____Height?_____

Were you ever treated with foot disorders as a child?_____
Were you ever treated with foot disorders as an adult?_____

Do you wear custom insoles (prescription orthotics)?_____

What is the foot or ankle problem that brought you to our office? Please be specific.

_____
_____
_____
_____

How long have you had this problem?_____

What makes it better?_____

What makes it worse?_____

Thank you for taking the time to answer these questions. Your answers will enable us to give you the kind of care that is best for your foot health needs. If you have any other medical concerns not listed above, please list them below or discuss them with the doctor.

_____