

## PATIENT MEDICAL HISTORY

What is your main foot or ankle complaint that you would like the doctor to address today?

How long has this been a problem? \_\_\_ days \_\_\_ weeks \_\_\_ months \_\_\_ years.

Have you had any prior treatment \_\_\_ yes \_\_\_ no; If so, what: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size \_\_\_\_\_

Any family history of: \_\_\_ Diabetes \_\_\_ Flat feet \_\_\_ Bunions \_\_\_ Hammertoes \_\_\_ Fungus

What is your Physician's name \_\_\_\_\_ Last exam \_\_\_\_\_

List any medicines or substances you are allergic to and your reaction:

Name: \_\_\_\_\_ Reaction \_\_\_\_\_

Name: \_\_\_\_\_ Reaction \_\_\_\_\_

Name: \_\_\_\_\_ Reaction \_\_\_\_\_

Please list all prescription and over the counter medicines you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy used: \_\_\_\_\_

Do you smoke? \_\_\_ yes \_\_\_ no; if so for how long? \_\_\_\_\_.

Alcohol: what type \_\_\_\_\_ Amount \_\_\_\_\_ How often \_\_\_\_\_.

Prior hospitalizations and surgeries:

(Month/Year)	(Condition)	(Month/Year)	(Condition)
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_____		_____	
_____		_____	
_____		_____	

Are you currently or have you been treated for any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Epilepsy/seizures       | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Phlebitis         |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Gastric reflux          | <input type="checkbox"/> Psychiatric care  |
| <input type="checkbox"/> Artificial joint            | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Rheumatic fever   |
| <input type="checkbox"/> Back/Neck pain (circle one) | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Blood clotting abnormality  | <input type="checkbox"/> Heart disease/ failure  | <input type="checkbox"/> swollen legs/feet |
| <input type="checkbox"/> Cancer: Type _____          | <input type="checkbox"/> Hepatitis/cirrhosis     | <input type="checkbox"/> Thyroid disease   |
| <input type="checkbox"/> Diabetes: How long _____    | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Ulcer             |
| <input type="checkbox"/> Deep vein thrombosis        | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Venous stasis     |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Kidney disease/dialysis | Other _____                                |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Neuropathy              | Other _____                                |

### FAMILY HISTORY

Any family history of: \_\_\_ Diabetes \_\_\_ Heart problems \_\_\_ Stroke \_\_\_ High blood pressure \_\_\_ Cancer

THANK YOU FOR FILING OUT THIS FORM. IT WILL HELP US GIVE YOU THE BEST  
PODIATRIC MEDICAL CARE.