Medical Information

Patient Name: _____ Date: _____

What is the Foot or Ankle problem that brings you to our office? Please be specific:_____

_____

Current Medical Conditions: (please list all condition even if no medication is needed) **Medications:**

1._____ 1. _____dose_____
2._____ 2. _____dose_____
3._____ 3. _____dose_____
4._____ 4. _____dose_____
5._____ 5. _____dose_____
6._____ 6. _____dose_____
7._____ 7. _____dose_____

Family Physician_____City_____Phone_____Last visit_____
Previous Podiatric Physician _____City _____Last visit_____

Have you or do you currently use any foot / shoe inserts in your shoes? _____

Have you ever had any of the following? Please check and write the **start date** you were affected.

____arthritis	____thyroid condition	____liver trouble	____anemia	____AIDS
____asthma	____stomach problems	____kidney trouble	____blood disease	____HIV
____shortness of breath	____diabetes	____heart trouble	____hepatitis	____TB
____cancer	____gout	____high blood pressure	____bleeding problems	
____stroke	____slow healing	____rheumatic fever	____blood clots / embolism	

Childhood Illnesses _____measles _____mumps _____chicken pox _____rheumatic fever _____scarlet fever
Previous injuries (fractures, dislocations, car accidents, etc…) _____
_____

Family History of Medical illnesses	Mother Age at death____	Father Age at death____	Grandparents Ages at death____	Siblings/ Other
Cancer				
Stroke				
High blood pressure				
Heart problems				
Diabetes				
Other				
Other				

Previous Hospital stays or Surgeries (including same day surgery & childbirth)

Reason: _____Date:_____
Reason: _____Date:_____
Reason: _____Date:_____
Reason: _____Date:_____
Reason: _____Date:_____
Reason: _____Date:_____
Reason: _____Date:_____

Allergies to medications: [ ] I have no known allergies to medications **or** [ ]adhesive tape [ ]codeine [ ] sulfa [ ]penicillin
[ ]local anesthetic [ ]iodine [ ]Other_____

Coffee / Caffiene Usage _____Cups per day **Alcohol / Recreational Drug Usage** [ ] Never [ ] Occasional Number of drinks per week _____ Prior or Current Alcohol / Drug Problem? ___yes ___no	**Tobacco Use** [ ] None Quit on _____ [ ] Cigarettes [ ] Pipe [ ] Cigar [ ] Chewing tobacco Number of years _____ Packs per day_____

Height _____ Weight _____ Shoe size _____ Width _____ Do your feet get tired at the end of day? [ ] Yes [ ] No

Signature: _____Relationship (if minor)_____Date_____