

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name of Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under the care of another physician?  YES  NO

If yes, name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

For what reason: \_\_\_\_\_

List all medications that you are currently taking and dosage amount:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

List any Medication Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any Food allergies?

\_\_\_\_\_  
\_\_\_\_\_

Please mark Medical Conditions you currently have or have had in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> artificial joints (hip,knee) | <input type="checkbox"/> heart disease                  | <input type="checkbox"/> neurological disorder          |
| <input type="checkbox"/> arthritis/rheumatism         | <input type="checkbox"/> heart attack/surgery           | <input type="checkbox"/> psychiatric/psychological care |
| <input type="checkbox"/> asthma/emphysema             | <input type="checkbox"/> hepatitis                      | <input type="checkbox"/> rheumatic fever                |
| <input type="checkbox"/> back injury                  | <input type="checkbox"/> high blood pressure            | <input type="checkbox"/> sickle cell anemia             |
| <input type="checkbox"/> cancer (Type:_____)          | <input type="checkbox"/> HIV positive                   | <input type="checkbox"/> stroke/CVA                     |
| <input type="checkbox"/> circulation problems         | <input type="checkbox"/> kidney problems                | <input type="checkbox"/> thyroid condition              |
| <input type="checkbox"/> DIABETES                     | <input type="checkbox"/> liver disease                  | <input type="checkbox"/> tuberculosis                   |
| <input type="checkbox"/> hyperlipidema/cholesterol    | <input type="checkbox"/> mitral valve prolapse          | <input type="checkbox"/> ulcers (stomach)               |
| <input type="checkbox"/> epilepsy or seizures         | <input type="checkbox"/> phlebitis or blood clot in leg | <input type="checkbox"/> OTHER _____                    |

List previous surgery:

Approximate month/year

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you had problems with anesthesia in the past?  YES  NO

Do you drink alcohol?  YES  NO Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you smoke?  YES  NO Former smoker?  YES  NO

Describe your foot or ankle problem: \_\_\_\_\_

When did this problem begin?

What types of treatment have you tried or had?