Advanced Footcare Group℠ Physician and Surgeon of the Foot and Ankle

MEDICAL HISTORY

Patient Name	Birth date / /

Allergies: List Known allergies or reactions to Drugs / Medications

❑ Penicillin or other antibiotic	❑ Sulfa	❑ Local Anesthetic	❑ Codeine/Percocet	❑ Anti-inflammatory Medication
❑ Nausea From Anesthetic	❑ Aspirin	❑ Adhesive Tape	❑ Iodine on Skin	❑ Cortisone
❑ Demerol	❑ Latex	❑ Ibuprofen	❑ Novocaine	❑ Other

Medications: Please list current medications that you are taking: Prescription or over the counter

Medication	Dose	Reason taking	Medication	Dose	Reason taking
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Foot/Ankle Pain How Long? Months Years Where?

Recently ill? Explain: Surgery? Explain:

What Previous Treatment Have you had on your Foot/Ankle?:

❑ Surgery	❑ Orthotics	❑ Oral Medications	❑ Cortisone Shots

Family Physician Information

Medical Doctor's Name	Phone Number ( ) -		
Street Address	City	State	Zip

Have you ever been put to sleep for surgery? ❑ yes ❑ no

Shoe Size	Height	Weight

Do you drink?	❑ yes ❑ no	**Drinks per week**	
Do you smoke?	❑ yes ❑ no	**How long?**	**Pack(s) per day**

Indicate which of the following you have had or have at present. Please check yes or no to each item

AIDS/HIV	❑ yes	❑ no		DIZZINESS/FAINTING	❑ yes	❑ no		MENOPAUSE	❑ yes	❑ no
ALCOHOLISM	❑ yes	❑ no		EMPHYSEMA	❑ yes	❑ no		NEUROLOGICAL DISORDER	❑ yes	❑ no
ANEMIA	❑ yes	❑ no		EPILEPSY/SEIZURES	❑ yes	❑ no		NEUROPATHY	❑ yes	❑ no
ARTHRITIS (RHEUMATOID)	❑ yes	❑ no		FIBROMYALGIA	❑ yes	❑ no		OBESITY	❑ yes	❑ no
ARTIFICIAL JOINTS	❑ yes	❑ no		Gastrointestinal PROBLEMS (REFLUX, HEARTBURN, ULCERS))	❑ yes	❑ no		OSTEOMYELITIS	❑ yes	❑ no
ASTHMA	❑ yes	❑ no		GLAUCOMA	❑ yes	❑ no		PHLEBITIS	❑ yes	❑ no
BLEEDING DISORDER (HEMOPHILIA)	❑ yes	❑ no		GOUT	❑ yes	❑ no		PSYCHIATRIC or PSYCHOLOGICAL CARE	❑ yes	❑ no
BLOOD CLOTS (DVT/PE)	❑ yes	❑ no		HEART DISEASE	❑ yes	❑ no		RAYNAUD'S	❑ yes	❑ no
BLOOD THINNER	❑ yes	❑ no		HEART MURMUR	❑ yes	❑ no		SICKLE CELL	❑ yes	❑ no
CANCER	❑ yes	❑ no		HEPATITIS	❑ yes	❑ no		SKIN CANCER	❑ yes	❑ no
CHEMICAL DEPENDENCY	❑ yes	❑ no		HIGH BLOOD PRESSURE	❑ yes	❑ no		THYROID DISEASE	❑ yes	❑ no
DEPRESSION	❑ yes	❑ no		INFECTION PRONE	❑ yes	❑ no		TUBERCULOSIS	❑ yes	❑ no
DIABETES	❑ yes	❑ no		KIDNEY DISEASE	❑ yes	❑ no		VASCULAR DISEASE	❑ yes	❑ no
DIALYSIS	❑ yes	❑ no		LIVER DISEASE	❑ yes	❑ no		VENEREAL DISEASE	❑ yes	❑ no

I understand the above medical information is necessary to provide me with medical care in a safe and efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you.

I will notify the doctor of any changes in my health condition or medication.

X	/ /
Patient/Guardian Signature	**Date**

History Reviewed by : Dr Signature : Date: / /