

# MEDICAL HISTORY

**Patient Name** \_\_\_\_\_

**DOB** \_\_\_\_\_

Allergies: List Known allergies or reactions to				Drugs /	Medications
<input type="checkbox"/> Penicillin or other antibiotic	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Codeine/Percocet	<input type="checkbox"/> Anti-inflammatory Medication	
<input type="checkbox"/> Nausea From Anesthetic	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Iodine on Skin	<input type="checkbox"/> Cortisone	
<input type="checkbox"/> Demerol	<input type="checkbox"/> Latex	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Novocaine	<input type="checkbox"/> 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.		

Hospitalizations/Surgeries	
_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

What Previous Treatment Have you had on your Foot/Ankle?:			
<input type="checkbox"/> Surgery	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Oral Medications	<input type="checkbox"/> 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	Recent Blood Pressure #	Height	Weight
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**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	<input type="checkbox"/> yes <input type="checkbox"/> no	DIZZINESS/FAINTING	<input type="checkbox"/> yes <input type="checkbox"/> no	MENOPAUSE	<input type="checkbox"/> yes <input type="checkbox"/> no
ALCOHOLISM	<input type="checkbox"/> yes <input type="checkbox"/> no	EMPHYSEMA	<input type="checkbox"/> yes <input type="checkbox"/> no	NEUROLOGICAL DISORDER	<input type="checkbox"/> yes <input type="checkbox"/> no
ANEMIA	<input type="checkbox"/> yes <input type="checkbox"/> no	EPILEPSY/SEIZURES	<input type="checkbox"/> yes <input type="checkbox"/> no	NEUROPATHY	<input type="checkbox"/> yes <input type="checkbox"/> no
ARTHRITIS	<input type="checkbox"/> yes <input type="checkbox"/> no	FIBROMYALGIA	<input type="checkbox"/> yes <input type="checkbox"/> no	OBESITY	<input type="checkbox"/> yes <input type="checkbox"/> no
ARTIFICIAL JOINTS	<input type="checkbox"/> yes <input type="checkbox"/> no	Gastrointestinal PROBLEMS (REFLUX, HEARTBURN, ULCERS)	<input type="checkbox"/> yes <input type="checkbox"/> no	OSTEOMYELITIS	<input type="checkbox"/> yes <input type="checkbox"/> no
ASTHMA	<input type="checkbox"/> yes <input type="checkbox"/> no	GLAUCOMA	<input type="checkbox"/> yes <input type="checkbox"/> no	PHLEBITIS	<input type="checkbox"/> yes <input type="checkbox"/> no
BLEEDING DISORDER (HEMOPHILIA)	<input type="checkbox"/> yes <input type="checkbox"/> no	GOUT	<input type="checkbox"/> yes <input type="checkbox"/> no	PSYCHIATRIC or PSYCHOLOGICAL CARE	<input type="checkbox"/> yes <input type="checkbox"/> no
BLOOD CLOTS (DVT/PE)	<input type="checkbox"/> yes <input type="checkbox"/> no	HEART DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> no	RAYNAUD'S	<input type="checkbox"/> yes <input type="checkbox"/> no
BLOOD THINNER	<input type="checkbox"/> yes <input type="checkbox"/> no	HEART MURMUR	<input type="checkbox"/> yes <input type="checkbox"/> no	SICKLE CELL	<input type="checkbox"/> yes <input type="checkbox"/> no
CANCER	<input type="checkbox"/> yes <input type="checkbox"/> no	HEPATITIS	<input type="checkbox"/> yes <input type="checkbox"/> no	SKIN CANCER	<input type="checkbox"/> yes <input type="checkbox"/> no
CHEMICAL DEPENDENCY	<input type="checkbox"/> yes <input type="checkbox"/> no	HIGH BLOOD PRESSURE	<input type="checkbox"/> yes <input type="checkbox"/> no	THYROID DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> no
DEPRESSION	<input type="checkbox"/> yes <input type="checkbox"/> no	INFECTION PRONE	<input type="checkbox"/> yes <input type="checkbox"/> no	TUBERCULOSIS	<input type="checkbox"/> yes <input type="checkbox"/> no
DIABETES	<input type="checkbox"/> yes <input type="checkbox"/> no	KIDNEY DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> no	VASCULAR DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> no
DIALYSIS	<input type="checkbox"/> yes <input type="checkbox"/> no	LIVER DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> no	VENEREAL DISEASE	<input type="checkbox"/> yes <input type="checkbox"/> 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:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_