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Medical History Form

Today's Date ______ / ______ / 20______

Patient Name: ____ Age: ________ Height: ________ Weight: _________

Primary Care Physician: __________________________________ Referring Physician: _____________________________________

Briefly describe foot or ankle problem: ____

□ Left □ Right □ Both   Is this an injury? □ Yes □ No   If "yes", when did the injury occur? _______________________________

Is this injury related to a work or auto accident? □ Yes □ No

How long have you had this problem? ____

Has this ever been treated by you or a physician before? If so, what has been done? ____

____

PLEASE CHECK ALL THAT APPLY BELOW:

□ Alcoholism
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Cancer (specify)_____________
□ Circulation Problems
□ Cirrhosis
□ Colitis
□ Congestive Heart Failure
□ COPD
□ Depression
□ Diabetes Type 1 / Type 2
□ Epilepsy
□ Gangrene
□ Gastritis
□ Gout
□ Hardening of Arteries
□ Hearing Impaired
□ Heart Disease
□ Heart Murmur / Irregular Heartbeat
□ High Blood Pressure
□ HIV / AIDS
□ Jaundice
□ Joint Replacement
□ Liver Disorder
□ Lung Disorder
□ Mitral Valve Disorder
□ Polio
□ Recreational Drug Use
□ Renal Failure
□ Rheumatic Fever
□ Stomach Disorder
□ Stroke
□ Thyroid Disorder
□ Tuberculosis
□ Ulcers
□ Other: ________________
□ Other: ________________
□ Other: ________________
□ Other: ________________
□ Other: ________________
□ Other: ________________
□ Other: ________________

Family history of □ Diabetes □ Heart Disease □ Cancer □ High Blood Pressure

Do you smoke ?   □ Yes □ No   If "yes", how many packs per day? __________ For how many years? ____________

Do you drink alcohol? □ Yes □ No   If "yes", how much and how frequently? ____

List any **surgeries** and year of the surgery: ____

____

List current **medications/herbal remedies** and dosage:____

____

List any **drug allergies**: ____

I HAVE FILLED OUT THIS MEDICAL HISTORY FORM HONESTLY AND TO THE BEST OF MY KNOWLEDGE.

Patient Signature: ____ Date ______ / ______ / 20 ______