

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICINES

	Name of Drug	Dosage	Purpose of Medication
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

No Medications at this time: _____ Women: List Birth Control Pill if applicable: _____
 *Do you routinely take aspirin or other antiinflammatory medicines (Advil, Alleve, etc.)? Yes _____ No _____

PRIOR SURGERY(S)

List your MOST RECENT surgery(s), even if done years ago. Please list the name of the hospital, out-patient surgery center, doctor, year, etc. if possible.

- No prior surgery(s): _____
 - (a) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (b) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (c) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (d) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (e) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (f) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
 - (g) Operation: _____ Doctor: _____ Year: _____
 Performed in: Hospital _____ Surgical Center _____ Office _____
3. Were there ANY adverse reactions to medications or anesthesia before, during, or after your surgery? Yes _____ No _____
 If yes REACTION(s): _____
4. Did you heal from your surgery WITHOUT ANY complications? Yes _____ No _____
 If yes Complication(s): _____

FAMILY HISTORY

*Please list ONLY the FOLLOWING FAMILY MEMBERS who have these illnesses or who have passed away from these illnesses: Mother, Father, Sisters, Brothers, Grandparents (maternal/paternal).

	Relative	Living (✓)	Age at Passing
CANCER (type):	_____	_____	_____
CLOTTING PROBLEMS:	_____	_____	_____
DIABETES:	_____	_____	_____
FOOT PROBLEMS:	_____	_____	_____
GOUT:	_____	_____	_____
HEART DISEASE:	_____	_____	_____
HIGH BLOOD PRESSURE:	_____	_____	_____
STROKE:	_____	_____	_____
THYROID PROBLEMS:	_____	_____	_____

SOCIAL HISTORY

Marital status: M _____ S _____ D _____ W _____ Sep _____
 Smoker: Yes _____ No _____ Packs/day _____ Years _____
 Alcohol: Yes _____ No _____ How often and how much _____
 Recreational Drugs: Yes _____ No _____
 Caffeine consumption: Regular Yes _____ No _____ Cup(s)/day _____
 (coffee, tea, soda) Decaff Yes _____ No _____ Cup(s)/day _____
 Exercise No _____
 Yes _____ type _____
 Hobbies: _____
 Have you ever been treated by a podiatrist before? Yes _____ No _____
 If so, what did he/she treat you for? _____

Patient Information

WE ARE PLEASED TO HAVE YOU AS A PATIENT. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

Patient Name _____ Pt. No. _____
 Home/Work Phone Numbers: () _____ H () _____ W _____
 Height: _____ Weight: _____ Shoe Size: _____ Employment: _____
 Age: _____ Sex: M / F
 Personal Physician: _____ City: _____
 First Last

Your last check-up by your Doctor: Month _____ Year _____ Unknown _____

If you are female, to your knowledge, are you pregnant? Yes _____ No _____

Foot Problems: _____

Past Treatment(s): _____

If yes, by whom: _____ When: _____

MEDICAL HISTORY

IF YOU WERE TREATED IN THE PAST, OR ARE NOW BEING TREATED FOR ANY OF THE ILLNESSES PLEASE PLACE A (✓) NEXT TO THE PROPER ILLNESS: DO NOT PUT YES OR NO IN EACH SLOT.

- | | | | |
|--|--------------------------|--|--------------------------|
| 1. AIDS | <input type="checkbox"/> | 16. Heart Problems (type) | <input type="checkbox"/> |
| 2. Anemia | <input type="checkbox"/> | 17. Hepatitis (type) | <input type="checkbox"/> |
| 3. Angina | <input type="checkbox"/> | 18. Hypertension (High Blood Pressure) | <input type="checkbox"/> |
| 4. Arthritis | <input type="checkbox"/> | 19. Hypotension (Low Blood Pressure) | <input type="checkbox"/> |
| 5. Asthma | <input type="checkbox"/> | 20. Kidney Problems | <input type="checkbox"/> |
| 6. Bleeding | <input type="checkbox"/> | 21. Liver Problems | <input type="checkbox"/> |
| 7. Blood Transfusion(s) | <input type="checkbox"/> | 22. Lung Problems | <input type="checkbox"/> |
| 8. Cancer (type): _____ | <input type="checkbox"/> | 23. Phlebitis | <input type="checkbox"/> |
| 9. CHF (Congestive Heart Failure) | <input type="checkbox"/> | 24. Pneumonia | <input type="checkbox"/> |
| 10. Diabetes: Type I _____ Type II _____ | <input type="checkbox"/> | 25. Rheumatic Fever | <input type="checkbox"/> |
| 11. Edema (swelling) | <input type="checkbox"/> | 26. Stomach Ulcer/Hiatus Hernia | <input type="checkbox"/> |
| 12. Emphysema | <input type="checkbox"/> | 27. Stroke | <input type="checkbox"/> |
| 13. Epilepsy | <input type="checkbox"/> | 28. Tuberculosis | <input type="checkbox"/> |
| 14. Glaucoma/Cataracts | <input type="checkbox"/> | 29. Vein/Artery Disease | <input type="checkbox"/> |
| 15. Gout | <input type="checkbox"/> | 30. Venereal Disease | <input type="checkbox"/> |

Other _____

CHILDHOOD ILLNESS (✓)

- | | | | |
|--------------------|--------------------------|-----------------------------|--------------------------|
| 1. Chicken Pox | <input type="checkbox"/> | 5. Rubella (German Measles) | <input type="checkbox"/> |
| 2. Measles | <input type="checkbox"/> | 6. Scarlet Fever | <input type="checkbox"/> |
| 3. Mumps | <input type="checkbox"/> | 7. Tuberculosis | <input type="checkbox"/> |
| 4. Rheumatic Fever | <input type="checkbox"/> | | |

Please list Any other illness you feel we should be aware of: _____

ALLERGIES: Have you experienced ANY ALLERGIC REACTIONS to the following: (✓)

- | | | | | | |
|----------------------|--------------------------|--------------------------------|--------------------------|--------------------------------|--------------------------|
| 1. Aspirin _____ | <input type="checkbox"/> | 7. Iodine _____ | <input type="checkbox"/> | 13. Sulfa _____ | <input type="checkbox"/> |
| 2. Bee Sting _____ | <input type="checkbox"/> | 8. Neosporin _____ | <input type="checkbox"/> | 14. Tape _____ | <input type="checkbox"/> |
| 3. Chemical(s) _____ | <input type="checkbox"/> | 9. Novocain _____ | <input type="checkbox"/> | 15. Tylenol _____ | <input type="checkbox"/> |
| 4. Clothing _____ | <input type="checkbox"/> | 10. Penicillin _____ | <input type="checkbox"/> | 16. X-ray dye _____ | <input type="checkbox"/> |
| 5. Codeine _____ | <input type="checkbox"/> | 11. Rag weed, Pollen _____ | <input type="checkbox"/> | 17. Other (metals, etc.) _____ | <input type="checkbox"/> |
| 6. Foods _____ | <input type="checkbox"/> | 12. Steroids (Cortisone) _____ | <input type="checkbox"/> | 18. Other antibiotics _____ | <input type="checkbox"/> |

Other _____

BLEEDING/SCARRING PROBLEMS (✓)

- | | | | | | |
|--------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| 1. Bruise easily | YES | NO | 4. Sickle cell disease | YES | NO |
| 2. Clotting problems | <input type="checkbox"/> | <input type="checkbox"/> | 5. Sickle cell trait | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Frequent nose bleeds: | <input type="checkbox"/> | <input type="checkbox"/> | 6. Scar poorly | <input type="checkbox"/> | <input type="checkbox"/> |

Blood Transfusions: Yes _____ No _____ IF yes Year(s) _____ Reason: _____

over please