

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 _____
- Were there ANY adverse reactions to medications or anesthesia before, during, or after your surgery? Yes _____ No _____
 If yes REACTION(s): _____
- 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? _____