MEDICAL HISTORY

PATIENT'S NAME ______________________________ DATE __________

Please describe your foot problem: ______________________________

Have you had any previous foot care or foot surgery?_____ If yes, by whom? ______________

PHARMACY ______________________________ Age: _______ Shoe Size: _______

Family Dr. ______________________________ Height: _______ Weight: _______

GENERAL HEALTH

Please check any of the following which you or your immediate family have been or are being treated.

For Immediate Family, use: (G) Grandparent, **(M)** Mother, **(F)** Father, **(S)** Sibling

Self	Immediate Family	
____	______	Arthritis (type)
____	______	Mitral Valve Prolapse (heart murmur)
____	______	A-Fib
____	______	Hypertension (high blood pressure)
____	______	Cardiac Disease (heart disease)
____	______	Peripheral Vascular Disease (circulation)
____	______	Tuberculosis
____	______	Gout
____	______	Cerebral Accidents (stroke)
____	______	Diabetes
____	______	Liver Disease (Hepatitis)
____	______	Renal Disease (kidney)
____	______	ADHD/ADD
____	______	Anxiety
____	______	Depression
____	______	Cancer **Type:** ______________
____	______	Fibromyalgia
____	______	Vertigo / Balance Problems
____	______	Cataracts
____	______	Knee / Hip Problems
____	______	Dementia
____	______	Alzheimer's

Self	Immediate Family	
____	______	Glaucoma/Eye
____	______	Breathing Problems / Asthma
____	______	Venereal Disease / AIDS / HIV+
____	______	Acid Reflux GERD, Stomach Ulcer
____	______	Polio, Cerebral Palsy, Muscular Dystrophy, MS
____	______	Phlebitis / Thrombophlebitis
____	______	Thyroid (hypo or hyper)
____	______	Slow Healer
____	______	Diverticulitis
____	______	Prostate Problems
____	______	High Cholesterol
____	______	Raynauds
____	______	Bleeding Disorder
____	______	Headaches/Migraines
____	______	Seizure Disorder / Epilepsy
____	______	COPD
____	______	Back Problems (Sciatica / Spinal Stenosis)
____	______	Hearing loss
____	______	Restless Legs
____	______	Parkinson
____	______	______________________
____	______	

Women, are you pregnant? _______ LMP _________ Due Date ______________

ALLERGIES _______ No Known Drug Allergies

Are you allergic to any of the below? Please check

____ Penicillin
____ Sulfa Drugs
____ Tetracycline
____ Iodine / Betadine
____ IV Contrast Dye
____ Cipro
____ Latex

____ Novocaine
____ Cortisone
____ Adhesive Tape
____ Caffeine
____ Aspirin
____ Codeine

____ Pain Medication ______________
____ Foods ______________
____ Environmental ______________
____ **Other** ______________

Continue on back side ⟶

PERSONAL SOCIAL HISTORY

	Circle One			
Tobacco:	**YES or NO**	**____ Cigarettes / Cigar**	**____ Smokeless / Oral**	**____ Previous Use**
Alcohol:	**YES or NO**	**____ Social**		
Caffeine:	**YES or NO**	**____ How Much**		

Activities ______________________________ **Exercise** ______________________________

Are you taking any medications? Yes________ **No**________ If yes, please list:

Please list all medications including Vitamins, Birth Control Pills, Herbs and any over the counter medications.
Please include milligrams and how you take the medication.

	Medication	Milligrams	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you had any previous surgery or hospitalization?

Yes________ **No**________ Please list: ______________________________

____

Are you under a doctor's care at the present time?

Yes________ **No**________

CONSENT FOR TREATMENT

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary by Ankle & Foot Care.

Date: ______________________________

X______________________________ ______________________________
Signature of patient or consenter Witness

CONSENT OF PHOTOGRAPHY

I hereby authorize Ankle & Foot Care to take medical photographs which are to be used solely for the purpose of education.

X______________________________ Date______________________________
Signature