MEDICAL HISTORY

NAME_____**AGE**____**SEX**____**RACE**____**DATE**_____

PAST MEDICAL HISTORY

Please circle any that apply:

Artificial Heart Valves
Artificial Joints
Arthritis
Asthma
Bleeding Disorders
Cancer
Diabetes
Emphysema
Gout
Heart Attack
HIV/Aids
Rheumatic Fever
High Blood Pressure
Low Blood Pressure
Liver Disease
Lung Disease
Lupus
Kidney Disease
Hepatitis
Thyroid Disease
Stroke
Ulcers (Stomach)
Seizure Disorders
Other_____

SURGERIES:

List any surgery and date (including foot surgery).

HOSPITALIZATIONS:

ALLERGIES

Circle any that apply or write NONE.

Penicillin
Erythromycin
Keflex
Sulfa
Codeine
Demerol
Hydrocodone
Tylenol
Aspirin
Anesthetics (local)
Anesthetics (general)
Tape
Iodine
Other_____

FAMILY HISTORY

Circle any that apply or write NONE.

Diabetes
Hypertension
Bleeding Disorders
Circulatory
Problems with anesthesia

SOCIAL HISTORY

Alcohol **YES **NO**
Tobacco **YES **NO**
Tobacco: How much a day____How long_____
If QUIT, How much did you smoke & how long_____

MEDICATIONS

Please list all including prescriptions, over-the-counter medications and vitamins.

FORMER FOOT DOCTOR: _____ LAST VISIT _____

FAMILY PHYSICIAN: _____ LAST VISIT _____

I certify that the above information is true and correct to the best of my knowledge.

Patient's Signature_____Date_____