Medical History

Family Podiatry Center
Physicians & Surgeons of the Foot & Ankle

Name: _____ Date: _____

Reason for visit: _____

Name of family physician: _____

Address of family physician: _____

HAVE YOU HAD OR STILL HAVE:	YES	NO
High blood pressure		
Heart disease including heart attack, stroke, chest pain, murmur, valves		
Chest pain with exertion Short of breath with exercise		
Short of breath when lying down		
Cardiac pacemaker		
Do your ankles swell?		
Diabetes		
If YES, how is it controlled?		
Do you urinate frequently?		
Are you often thirsty?		
Is your mouth dry?		
Do you have numbness or tingling in your fingers or toes?		
Arthritis		
Rheumatoid arthritis		
Gout		
Do you have painful joints?		
Circulatory or vascular disease		
Phlebitis and/or blood clots		
Leg cramps while walking		
Leg cramps at rest		
Varicose Veins		

HAVE YOU HAD OR STILL HAVE:	YES	NO
Lung disease		
Kidney disease		
Liver disease, hepatitis or jaundice		
Stomach ulcers		
Asthma, hay fever, hives,sinuses or allergies		
Abnormal bleeding/healing		
Do you bruise easily?		
Anemia or blood disorders		
Sickle cell anemias		
Keloids/Enlarged scars		
Rheumatic fever		
Glaucoma		
Low back pain		
Psychiatric problems		
Tuberculosis		
Venereal disease		
Epilepsy or seizures		
Cancer		
AIDS or immunosuppressive disorders		
WOMEN ONLY:		
Could you be pregnant?		
Are you nursing?		
Do you still menstruate?		
Problems with your periods?		

ARE YOU ALLERGIC TO:	YES	NO
Local anasthetics		
Novocaine		
Penicillin or antibiotics		
Sulfa drugs		
Aspirin		
Codeine, demerol or other narcotics		
Iodine		
Tape		
Nylon or plastics		
Other:		

ARE YOU TAKING MEDICATIONS:	YES	NO
For blood pressure		
Diuretics (water pills)		
Nitroglycerin/heart pills		
Blood thinners		
Steriods, cortisone		
Tranquilizers/sleeping pills		
Antibiotics		
Anthistamines		
Insulin/Type		
Other Diabetic Meds		
Birth control/hormones		
Other:		

Do you have any disease, condition or problem not listed on the first page?

Explain: _____

_____

Have you been hospitalized or had a serious illness within the past 10 years? _____

Explain _____

Have you had surgery, injury or treatment of your feet or ankles? _____

Explain: _____

_____

Do you participate in any athletic activities, exercise or sports? _____

_____

Any hobbies? _____

Do you smoke? _____ Packs per day _____ How many years? _____

How often do you drink alcoholic beverages? _____

Other? _____

Has anyone in your family (parents, siblings, children) had:

High blood pressure: _____ Heart disease: _____ Cancer: _____ Diabetes: _____

Foot problems (explain): _____

_____

I certify that I have read and understand the above on both pages. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my podiatrist or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Furthermore, I hereby give my permission to Dr.'s Reid/Kosova or his/her associates to examine and administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____