

Michigan Foot & Ankle Institute



Stacey L. Miller, DPM

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Patient Name _____

Primary Care Physician: First Name _____ Last Name _____

Phone #: _____ Location/City: _____

Patient's Pharmacy: Name _____ Location/City _____

Phone Number _____

Please list any drug allergies: _____

Are you allergic to any of the following: Iodine Latex Shellfish Stainless steel Talc Tape

Please list medications you take regularly:

Height: _____ Weight: _____ Are you pregnant? Yes No

Do you smoke? _____ If yes, how many packs per day? _____ for # _____ years If no, when did you quit? _____

Do you drink alcohol? _____ How much? _____

List any past surgical history: _____

If you have had or have any of the following, please circle:

AIDS/HIV	Edema	Myocardial infarction (heart trouble)
Alzheimer's Disease	Glaucoma	Nephrotic syndrome (kidney problem)
Anxiety	Gout	Phlebitis
Anemia	Hepatitis	Polio
Atherosclerosis	Hypercholesterolemia (high cholesterol)	PVD
Arthritis	Hypertension (high blood pressure)	Rheumatic Fever
Asthma	Hyperthyroid	Seizures
Atherosclerosis (circulation)	Hypotension (low blood pressure)	Stroke
Bleeding disorder	Hypothyroid	Tuberculosis (TB)
Cancer	Leg cramps	Ulcers
Cirrhosis of liver	Low back pain	Varicose veins
Depression	MRSA	
Diabetes Type 1 Type 2		

Name of physician who manages your diabetic condition: _____

Are you insulin dependent? _____ Date of your last diabetic eye exam: _____

Please list family members who have diabetes (example: mother/father): _____

Any other medical history _____

My Foot/Ankle problem is: _____

How long have you had this problem? _____

Did this incident happen at work or a result of an auto accident? _____

Patient or Legal Guardian Signature _____ Date _____