MEDICAL HISTORY

Name _____ Birth Date _____/_____/_____
(First Middle Last) (month / day / year)

Chief Foot / Ankle Complaint _____

Please check all applicable medical conditions that apply to you:

____ Arteriosclerosis
____ Arthritis
____ Asthma
____ Anemia
____ Bronchitis
____ Cancer
____ Diabetes
____Emphysema
____ Fainting
____ Glaucoma
____ Gout
____ Heart Disease
____ Hemophilia
____ Hepatitis
____ High Blood Pressure
____ High Cholesterol
____ HIV/AIDS
____ Joint Pain/Stiffness
____ Kidney Problems
____ Liver Disease
____ Muscle Spasms
____ Other _____
____ Stroke/Seizures
____ Thyroid Problems
____ Tuberculosis
____ Ulcers

Family History:

____ Arthritis
____ Cancer
____ Diabetes
____ Heart Disease
____ High Blood Pressure
____ Vascular Disease

Social History:

Do you smoke? Yes | No If yes, how much per day? _____
Did you quit smoking? Yes / No
Do you drink alcohol? Yes | No If yes, how much per day? _____

Surgical History:

1. _____ Year: _____ 3. _____ Year: _____

2. _____ Year: _____ 4. _____ Year: _____

Current Medications:

1. _____ 3. _____ 5. _____ 7. _____ 9. _____

2. _____ 4. _____ 6. _____ 9. _____10. _____

Known Allergies to Medication:

1. _____ 2. _____ 3. _____4.

Preferred Pharmacy include the Street name:

_____

_____ _____
Signature Date