

MEDICAL HISTORY

PATIENT NAME _____

BIRTH DATE ____/____/____

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS)

| | | | |
|-------------------------------------|--------------------------------|---|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Anti-Inflammatory Medication |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tape | <input type="checkbox"/> Nausea From Anesthetic | <input type="checkbox"/> Iodine on Skin |
| <input type="checkbox"/> Other | <input type="checkbox"/> None | | |

**MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING:
PRESCRIPTION AND OVER-THE COUNTER)**

Use Other Side Of Page If Necessary

| MEDICATION | DOSE | MEDICATION | DOSE |
|------------|------|------------|------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

CHIEF COMPLAINT? _____ **HOW LONG?** _____ **MONTHS** _____ **YEARS** _____

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

Surgery Orthotics Oral Medications Cortisone Shots

WHAT OTHER SURGERIES HAVE YOU HAD? _____ **DATE** _____

FAMILY PHYSICIAN INFORMATION

| | | | | |
|----------------|--------------------|---------------------------|-------|----------|
| Doctor's Name | Date of Last Visit | Phone Number (____) _____ | | |
| Street Address | | City | State | Zip Code |

SHOE SIZE _____ **HEIGHT** _____ **WEIGHT** _____

DO YOU DRINK? NO YES **DRINKS PER WEEK** _____

DO YOU SMOKE? NO YES **PACK(S) PER DAY** _____

Indicate which of the following you had or have at present. Check Yes or No to each item

| | | | | | |
|-------------------------------------|------------------------------|-----------------------------|---------------------------------------|------------------------------|-----------------------------|
| Arthritis/Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Communicable Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Motion Sickness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart (Surgery, Disease, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric/Psychological Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mitral Valve Prolapse/Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach Problems / Reflux / Heartburn | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is there a chance you may be pregnant? Yes No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the office of any change in my health or medication.

X

Patient/Guardian Signature

Date

HISTORY REVIEWED BY: DR. SIGNATURE

DATE