



MEDICAL HISTORY

(Please Print)

PATIENT NAME _____ BIRTHDATE _____ / _____ / _____

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

Pharmacy Name (Do you have a preferred pharmacy for us to call a prescription in to)

Name _____ City _____

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

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE? _____ **HOW LONG?** _____ MONTHS _____ YEARS

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

Surgery Orthotics Oral Medications Cortisone Shots

PRIMARY CARE PHYSICIAN

Please Indicate Primary Care Physician _____ 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) / DAY:** _____

Indicate which of the following you have 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	H.I.V. Positive	<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
Fibromyalgia	<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, Attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems/Reflux/Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A (Infectious B (serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Put to sleep for surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> 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 doctor of any changes in my health or medication.

X

Patient/Guardian Signature _____ **Date** _____

HISTORY REVIEWED BY: DR. SIGNATURE _____ DATE _____