

**PATIENT MEDICAL INFORMATION**

(Confidential Information - Important For Our Files And Your Health)

- A. Family Physician \_\_\_\_\_
- B. Has he / she requested you to be seen in our office? Yes or No
- C. Former Foot / Ankle Specialist \_\_\_\_\_
- D. What did he / she treat you for? \_\_\_\_\_

**Pre - History Form**

- 1a. State your medical reason(s) for coming to our office today. \_\_\_\_\_
- 1b. How long has this been a problem? \_\_\_\_\_
- 1c. State any treatments you have done either on your own or prescribed. \_\_\_\_\_
- 2a. Please list all medications (prescribed or over the counter), dosages and how often you use them? \_\_\_\_\_
- 2b. Taking/Using? Garlic Ginger Gingko Bilboa Ginseng St.Johns Wort Butcher's Broom Other \_\_\_\_\_
- 3. FOR WOMEN ONLY: Are you pregnant ? \_\_\_\_\_ If so, how many months? \_\_\_\_\_

4. Family history: Please inform us of the health of your family members as best you can. Indicate if any have had: Foot/Ankle Problems, Cancer, Heart Trouble, Kidney Disease, Stroke, Diabetes, High Blood Pressure, Arthritis.

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

Children \_\_\_\_\_

- 5a. Do You Smoke? Yes No \_\_\_ packs/day/\_\_\_ years. 5b. Do You Drink Alcohol? Yes No \_\_\_ oz/day/week.
- 5c. Do You Or Have You Used Drugs?(i.e.: Cocaine, Marijuana, etc.) Yes No Which one(s)? \_\_\_\_\_
- 8. Please check the boxes below "Yes" or "No" to all the conditions listed below.

- |                              |                             |                             |                              |                             |                                         |
|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|-----------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Diabetes</b>             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Rheumatic Fever</b>                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Recent Weight Loss</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Skin</b>                             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Heart Problems</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Arthritis</b>                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>High Blood Pressure</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Gout</b>                             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Stroke</b>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Tuberculosis</b>                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Asthma</b>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Epilepsy/Seizures</b>                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Vision Trouble</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Cancer</b> _____                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Trouble with Hearing</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Nervous Condition</b>                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Stomach Ulcers</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Venereal Disease</b>                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Anemia</b>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>HIV Positive/AIDS/ARC</b>            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Kidney Problems</b>      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Thyroid Disease</b> _____            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Liver Problems</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Numbness in feet or legs</b>         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Bleeding Tendency</b>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Pain in feet or legs at night</b>    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Bad Circulation</b>      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Pain in feet /legs when you walk</b> |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Phlebitis</b>            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>OTHER</b> _____                      |

- 9. Have you had any Operations or Serious Injuries? Yes No Please give details -----
- 10. Have you experienced any unusual or allergic reactions to any medication? Yes No  
IF YES, WHICH ONE (S)? Penicillin Novocain Cortisone Iodine Dyes Sulfa  
Band-Aids or Adhesive Tape Other \_\_\_\_\_
- 11. IS THERE ANY OTHER IMPORTANT INFORMATION ABOUT YOUR HEALTH?

12. Signature: \_\_\_\_\_ Date: \_\_\_\_\_