Medical History Form (1)

Name: _____
Last, Name, First Name

PRESENT ILLNESS OR INJURY

What is the reason (problem) for your visit to our office?

_____

_____

_____

_____

Who is your Primary Care Physician? (i.e internist)

_____

Have you seen this or any another physician regarding this problem?

☐ Yes ☐ No

If Yes, please list: Doctor: _____

Date last seen by this Doctor: _____

How were you referred to our practice?

☐ Another doctor ☐ Listed in your insurance guide

☐ Friend ☐ Family member ☐ Advertisement

Other (explain): _____

MEDICAL HISTORY

What is your current smoking status?

☐ Current every day smoker ☐ Current some day smoker

☐ Former smoker ☐ Never smoked

Please indicate which foot/ankle problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Feet /Legs
☐ Flat Feet
☐ Heel pain
☐ Ingrown Nails
☐ Numbness in Feet, Legs, Toes
☐ Plantar Warts
☐ Swelling in Feet, Legs, Toes
☐ Tired Feet

Have you been diagnosed with any of the following?

(you must indicate Yes or No)	Yes	No
Diabetes	☐	☐
Hypertension	☐	☐
Peripheral Vascular Disease	☐	☐
Onychomycosis	☐	☐
Plantar Fasciitis	☐	☐

Have you been prescribed foot orthotics? ☐ Yes ☐ No

If yes, do you still use them? ☐ Yes ☐ No

ALLERGIES

Please tell us of any allergies you have and potential reactions (i.e nausea, hives) when encountered:

☐ Aspirin: _____

☐ Codeine: _____

☐ Demerol: _____

☐ Iodine: _____

☐ Novocain: _____

☐ Penicillin: _____

☐ Sulfa: _____

Other: _____

☐ NONE

MEDICATIONS

Please list any medications you are currently taking. If you require more space or would like a list of common medications please ask our receptionist to provide one.

_____

_____

_____

_____

_____

SURGICAL / INJURY HISTORY

List the type of injury or surgery and date:

_____

_____

_____

_____

PHARMACY

What is your preferred pharmacy?

Name: _____

Location: _____