

## MEDICAL HISTORY

**PLEASE CHECK TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:**

AIDS/HIV _____ ANEMIA _____ ANXIETY _____ ARTHRITIS _____ ARTIFICIAL HEART VALVE _____ ARTIFICIAL JOINTS _____ LOCATION _____ ASTHMA _____ BACK PROBLEMS _____ TYPE _____ BLEEDING DISORDER _____ TYPE _____ CANCER _____ TYPE _____ KIDNEY DISEASE _____ TYPE _____ PHLEBITIS _____ RHEUMATIC FEVER _____ THYROID DISEASE _____ HYPO _____ HYPER _____ UNEXPLAINED WEIGHT GAIN/LOSS _____	CHEMICAL DEPENDENCY ____ (DRUGS/ALCOHOL) CHEST PAIN ____ CAUSE _____ DIABETES _____ HOW LONG? _____ EPILEPSY _____ GI DISORDER _____ TYPE _____ GOUT _____ HEART DISEASE _____ HEPATITIS _____ HIGH BLOOD PRESSURE _____ HIGH CHOLESTEROL _____ LIVER DISEASE _____ RESPIRATORY DISEASE _____ STROKE _____ TUBERCULOSIS _____ VENEREAL DISEASE _____
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**CIGARETTE/TOBACCO USE:** YES/NO HOW LONG? \_\_\_\_\_ **QUIT?** YES/NO NEVER USED \_\_\_\_\_

**ALCOHOL USE:** YES/NO HOW OFTEN? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

**ORAL CONTRACEPTIVE USED CURRENTLY?** YES/NO

**FOOT/ANKLE: WHAT FOOT/ANKLE PROBLEMS ARE YOU BEING SEEN FOR TODAY?** \_\_\_\_\_

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**PLEASE CIRCLE IF YOU HAVE EXPERIENCED OR IF YOU ARE NOW EXPERIENCING ANY OF THE FOLLOWING:**

ANKLE PAIN	CALLUSES/CORN	HEEL PAIN	PLANTARS WARTS	ATHLETES FOOT
CRAMPS IN FEET/LEGS	INGROWN TOENAILS	SWELLING FEET/ANKLES	BUNIONS	FLAT FEET

**HAVE YOU BEEN PREVIOUSLY TREATED BY A PODIATRIST?** YES/NO DOCTOR'S NAME: \_\_\_\_\_ DATE TREATED \_\_\_\_\_

**ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE AND FREQUENCY (E.G. WALKING 2 MILES/DAY):** \_\_\_\_\_

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**ALLERGIES: PLEASE CIRCLE ANY THAT APPLY.**

ADHESIVE TAPE	DEMEROL	NOVOCAIN	SULFA	ASPRIN/ASA	IODINE	PENICILLIN/PCN
CODEINE	SEAFOOD	LOCAL ANESTHETICS	NO KNOWN DRUG ALLERGIES OTHER: _____			

**WHAT TYPE OF REACTION OCCURS?** \_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING INCLUDING OVER THE COUNTER MEDICATIONS AND SUPPLEMENTS:** \_\_\_\_\_

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**ALL PREVIOUS SURGERIES (PLEASE LIST TYPE AND YEAR, E.G. HERNIA REPAIR, 2008):** \_\_\_\_\_

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**ALL PREVIOUS MEDICAL HOSPITALIZATIONS (PLEASE GIVE YEAR/REASON; E.G. PNEUMONIA, 2007):** \_\_\_\_\_

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**FAMILY MEDICAL HISTORY-ANY MEDICAL PROBLEMS THAT ARE PRESENTLY IN YOUR IMMEDIATE FAMILY (E.G. HEART DISEASE-MOTHER):**

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I CERTIFY THAT THE INFORMATION SUBMITTED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE PERMISSION TO SHARI KAMINSKY, DPM OR JERRY LIDDELL, DPM TO ADMINISTER AND PERFORM PROCEDURES AS DEEMED NECESSARY IN MY DIAGNOSIS AND TREATMENT.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_