PATIENT MEDICAL HISTORY

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415 898 9818

Patient's Name _____

CIRCLE EACH ANSWER

1. Are you having pain or discomfort TODAY? ..... YES NO
2. Have you had any surgeries before (not just foot-related)? ..... YES NO
   If YES, list here _____
3. Have you been a hospital patient during the past 2 years? ..... YES NO
4. Have you been under the care of any doctor during the past 2 years? ..... YES NO
   Doctor's Name/Phone _____
5. Have you taken any medications or drugs during the past 2 years? ..... YES NO
6. Are you now taking any medications or pills? ..... YES NO
   If YES, list here _____
7. Are you aware of being **allergic** to/have you ever reacted adversely to any medications or substances? ..... YES NO
   If YES, list here: _____
8. When you take a walk or walk up stairs, do you ever have to stop because of pain in your chest or calves or because you are short of breath? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you have difficulty when taking anti-inflammatory medicine (Advil®, Aleve®)..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Has your doctor ever said you have cancer or a tumor? ..... YES NO
13. ***CIRCLE*** each of the following which you currently have or have had:

Heart Failure	Arthritis	Chronic Cough	HIV
Heart Disease/Attack	Rheumatism	Tuberculosis	Hemophilia
Angina Pectoris	Cortisone Medicine use	Asthma	Anemia
Congenital Heart Disease	Drug Addiction	Hay Fever	Sickle Cell Disease
Heart Murmur	Stroke	Allergies/Hives	Bruising Easily
High Blood Pressure	Artificial Joints (hip, knee)	Radiation Therapy	Liver Disease
Arteriosclerosis	Kidney Trouble	Chemotherapy	Yellow Jaundice
Artificial Heart Valve	Ulcers	Hepatitis A (Infectious)	Epilepsy/Seizures
Mitral Valve Prolapse	**Diabetes**	Hepatitis B (Serum)	Fainting/Dizzy Spells
Heart Pacemaker	Thyroid Problems	Hepatitis C	Nervousness
Rheumatic Fever	Glaucoma	Venereal Disease	Psychiatric Treatment
Deep Vein Thrombosis	Emphysema	AIDS	

14. PRINT other disease/condition/problem you have _____
15. Do you drink alcohol? ..... YES NO
16. Do you smoke cigarettes? ..... YES NO
17. Height _____ Weight _____

-----FOR WOMEN ONLY -----

18. Are you taking birth control pills? ..... YES NO
19. *Are you pregnant?* ..... YES NO
    If YES, what month? _____
20. *Are you nursing?* ..... YES NO

I, the undersigned, understand the above information is necessary to provide me with the best medical care in a safe, efficient manner. I have answered all questions truthfully and to the best of my knowledge:

Patient's Signature (or that of a Parent of Guardian for a minor) Date