

**PATIENT MEDICAL HISTORY & INFORMATION**

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**Patient's Name** \_\_\_\_\_

**Preferred Pharmacy Name/Location:** \_\_\_\_\_

List current medications:

\_\_\_\_\_

List allergies to medications and substances:

\_\_\_\_\_

Do you have difficulty when taking anti-inflammatory medicine (Advil®, Aleve®)..... YES NO

List all past surgeries (not just foot related):

\_\_\_\_\_

List all hospitalizations in the past 2 years:

\_\_\_\_\_

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  
Have you lost or gained more than 10 pounds in the last year? ..... YES NO

**CIRCLE** each of the following which you currently have or have had:

- |                          |                               |                          |                        |
|--------------------------|-------------------------------|--------------------------|------------------------|
| Heart Failure            | Deep Vein Thrombosis          | Thyroid Problems         | Hepatitis C            |
| Heart Disease/Attack     | Peripheral Vascular Disease   | Glaucoma                 | Venereal Disease       |
| Angina Pectoris          | Venous Insufficiency          | Emphysema                | HIV/AIDS               |
| Congenital Heart Disease | Arthritis                     | Chronic Cough            | Hemophilia             |
| Heart Murmur             | Rheumatism                    | Tuberculosis             | Anemia                 |
| High Blood Pressure      | Drug Addiction                | Asthma                   | Sickle Cell Disease    |
| Arteriosclerosis         | Stroke                        | Cancer                   | Bruising Easily        |
| Artificial Heart Valve   | Artificial Joints (hip, knee) | Radiation Therapy        | Liver Disease/Jaundice |
| Mitral Valve Prolapse    | Kidney Trouble                | Chemotherapy             | Epilepsy/Seizures      |
| Heart Pacemaker          | Ulcers                        | Hepatitis A (Infectious) | Fainting/Dizzy Spells  |
| Rheumatic Fever          | <b>DIABETES</b>               | Hepatitis B (Serum)      | Psychiatric Treatment  |

PRINT any other disease/condition/problem you have \_\_\_\_\_

Do you drink alcohol?....CURRENT PAST NEVER Number of drinks \_\_\_\_\_ per day or per week (circle one)

Do you smoke cigarettes?.....CURRENT PAST NEVER Number of packs \_\_\_\_\_ per day or per week (circle one)

Do you smoke e-cigarettes?...CURRENT PAST NEVER Number of cartridges \_\_\_\_\_ per day or per week (circle one)

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**FOR WOMEN ONLY**

Are you taking birth control pills? ..... YES NO

Are you pregnant? ..... YES NO

If YES, what month? \_\_\_\_\_

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 or Guardian for a minor)

Date