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	**DIABETES**	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 of Guardian for a minor) Date