PATIENT MEDICAL HISTORY & INFORMATION

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Patient's Name _____

List current medications:

_____

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

List allergies to medications and substances:

_____

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:

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

PRINT any other disease/condition/problem you have _____

Do you drink alcohol?.....YES NO Number of drinks_____per day or per week (circle one)

Do you smoke cigarettes?.....YES NO Number of packs_____ per day or per week (circle one)

Height _____ Weight _____

Preferred Pharmacy Name/Location:

_____

_

-----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