



PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Shoe Size** _____

Current Foot or Ankle problem: _____

When did the problem start? _____

What has been done to treat the problem? _____

Are you now or have you ever been under a physician's care in the past two years? _____

If yes, please explain: _____

Name of Family Physician: _____ Date last seen: _____

Name of Former Podiatrist/Foot & Ankle Specialist: _____ Date last seen: _____

What conditions were you treated for: _____

MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney (Renal) or Bladder diseases | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Heart/Coronary Artery Disease | <input type="checkbox"/> Anemia (low Fe/sickle cell) | <input type="checkbox"/> Depression or Anxiety |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Asthma / Bronchitis | <input type="checkbox"/> Vascular / Circulatory Disease |
| <input type="checkbox"/> Stroke (CVA) or Heart Attack | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Stomach Ulcer / Reflux | <input type="checkbox"/> Accident / Injuries | <input type="checkbox"/> Arthritis (OA/RA/Charcot/etc) |
| <input type="checkbox"/> Hypercholesterol | <input type="checkbox"/> Immunological Diseases | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Liver Disease (ie. Hepatitis) | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Other |

Please explain any positive responses above:

MEDICATIONS (please include dosage of each); Please use back if necessary or Provide attachment list

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____



ALLERGIES. (Penicillin? Sulfa? Codeine? Local anesthesia? Injectable Dye? Tape? Foods? etc.); Please indicate symptom(s)

- 1. _____ 3. _____ 5. _____
- 2. _____ 4. _____ 6. _____

SURGERIES / HOSPITALIZATIONS (describe procedure, year, and any complications); Please use back if necessary

- 1. _____
- 2. _____
- 3. _____
- 4. _____

SOCIAL HISTORY

Occupation: _____ Tobacco: If yes, how much/long? _____

Alcohol: If yes, how much? _____ Illicit drugs: If yes, what kind? _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other):

FEMALE: Pregnant? *Please Circle* NO YES How far along? _____

Name and Phone number of Ob/Gyn? _____

Whom may we thank for referring you to our office? _____

I hereby give ELITE FOOT & ANKLE permission to diagnose and administer treatment for my foot and ankle condition(s) and authorize any release of information obtained in the course of my treatment.

Patient / Guardian Signature: _____ **Date:** _____

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