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

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

PREFERRED PHARMACY

Name:_____ Phone #:_____

Address:_____

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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