FILL OUT THIS FORM ONLY IF YOU HAVE NOT BEEN SEEN BY US IN 2 YEARS.

AFFILIATES IN PODIATRY PC

PATIENT NAME:
DOB:
PCP:

## MEDICAL HISTORY

CHIEF FOOT COMPLAINT:_____

ALLERGIES TO MEDICATION:_____

MEDICATIONS BEING TAKEN:_____

PREVIOUS SURGERY:_____

DO YOU SMOKE: YES ☐ NO ☐ ARE YOU PREGNANT: YES ☐ NO ☐

ANY FAMILY HISTORY OF: HIGH BLOOD PRESSURE ☐ CANCER ☐ STROKE ☐

DIABETES ☐ HEART PROBLEMS ☐

HAVE YOU EVER HAD OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING:

| | | | | | |
|---|---|---|---|---|---|
| ANEMIA | YES ☐ | NO ☐ | HIGH BLOOD PRESSURE | YES ☐ | NO ☐ |
| ANGINA | YES ☐ | NO ☐ | KIDNEY DISEASE | YES ☐ | NO ☐ |
| ARTHRITIS | YES ☐ | NO ☐ | PACEMAKER | YES ☐ | NO ☐ |
| ARTIFICIAL JOINT | YES ☐ | NO ☐ | PHLEBITIS | YES ☐ | NO ☐ |
| ASTHMA | YES ☐ | NO ☐ | PROLONGED BLEEDING | YES ☐ | NO ☐ |
| BLADDER PROBLEM | YES ☐ | NO ☐ | PSYCHIATRIC CARE | YES ☐ | NO ☐ |
| CANCER | YES ☐ | NO ☐ | RHEUMATIC FEVER | YES ☐ | NO ☐ |
| CHEST PAIN | YES ☐ | NO ☐ | SCARLET FEVER | YES ☐ | NO ☐ |
| DIABETES | YES ☐ | NO ☐ | STROKE | YES ☐ | NO ☐ |
| EMPHYSEMA | YES ☐ | NO ☐ | SUGAR IN URINE | YES ☐ | NO ☐ |
| EPILEPSY OR SEIZURE | YES ☐ | NO ☐ | SWOLLEN ANKLES | YES ☐ | NO ☐ |
| GLAUCOMA | YES ☐ | NO ☐ | THYROID DISEASE | YES ☐ | NO ☐ |
| GOUT | YES ☐ | NO ☐ | TUBERCULOSIS | YES ☐ | NO ☐ |
| HEART ATTACK | YES ☐ | NO ☐ | ULCER | YES ☐ | NO ☐ |
| HEPATITIS / LIVER DISEASE | YES ☐ | NO ☐ | | | |

ANY CONDITION NOT MENTIONED HERE_____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____ PHARMACY _____