Medical History

Name____

Height__________________ Weight____________________ Blood Pressure_____________________

Primary Care Provider____

When did you last see your Primary Care Provider? ______________________________

DO YOU OR ANY OF YOUR FAMILY HAVE A HISTORY OF:

___Heart Disease ___High Blood Pressure ___Diabetes ___Asthma

___Kidney Disease___ Circulatory Problems ___Cancer ___Blood Clotting

___Rheumatic Fever ___Stomach Problems/Ulcers

DO YOU SMOKE? No ___Yes____ HOW MUCH _______ HOW MANY YEARS___

OTHER TOBACCO No ____ Yes____ DRINK ALCOHOL? No____ Yes_____

Current Medications____

____

____

Are you allergic to any of the following?

___*PENICILLLIN* ___*ASPIRIN* ___*TAPE* ___*ANESTHETICS*

___OTHER MEDICATIONS____

Have you ever had a bad reaction to any medications?

____

Have you ever had foot or leg surgery? YES______ NO________

When?________________ Surgeon______________________

Please describe the foot or ankle problem you are having:______________________________

____

How long have you had this problem? ______________________________

Is there anything else we should know about you before treating you?

____

____

To the best of my knowledge, the information provided here is true.

____

Signature **Date**