Comprehensive Foot Centers, P.A.

Patient Medical Information and History Form

Patient Name: First_____ M.I._____ Last_____

Drug Allergies:_____

Other Allergies:_____

Current Medications: _____

_____

_____

Exercise/Activities: _____

Social History

Cigarette/Tobacco Use: Never Smoked Current Smoker Former Smoker How much a day? _____

For how many years? _____ When did you quit? _____ **Do you use recreational drugs?** Yes or No

Do you drink alcohol? Yes or No Number of drinks per week: _____ **Caffeine Intake:** None Coffee Soda Tea Other: _____

Family History

Is there a history of Arthritis, Cancer, Diabetes, Gout, Heart Disease, High blood pressure, or other medical condition in your family? Please list your family member and their medical condition(s): _____

_____

_____

Patient Surgical History

Please list any prior surgeries you have had and the year it was performed:

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Patient Medical History

Please circle any of the following conditions if you currently have or previously had them in the past:

AIDS/HIV	Anemia	Angina	Arthritis	Artificial Heart Valves
Artificial Joints	Asthma	Back Pain	Bleeding Tendency	Cancer
Chest Pain	Chronic Diarrhea	Circulatory Problems	COPD	Diabetes
Foot & Leg Cramps	Glaucoma	Gout	Headaches	Heart Attack
Heart Disease	Hepatitis	High Blood Pressure	High Cholesterol	Jaundice
Seasonal Allergies	Seizures	Shortness of Breath	Sinus Problems	Stroke
Swollen Ankles/Feet	Thyroid Problems	Tired Feet	Ulcers	Varicose Veins

Other: _____

Have you seen a podiatrist before? Yes or No **Who was your last podiatrist?**_____ **Date of last visit with them:** _____

Please describe and indicate on the diagram below the areas the doctor will be addressing this visit: _____