Confidential Patient Medical Information

Print your full legal name:_____

Describe your foot problem: _____

_____

_____

(Circle one) Right foot or Left foot or Both feet

How long have you had this problem? Number of Days:_____ Weeks:_____ Years: _____

Describe past treatment for this problem:_____

_____

Describe past surgery for this problem:_____

_____

Describe any medications or injections taken for this problem: _____

MEDICATIONS

Are you allergic or sensitive to: (circle) Penicillin Sulfa Betadine (iodine) Lidocaine

List other drugs you are allergic to:_____

Have you had any problem taking aspirin or ibuprofen (Advil, Motrin)? Yes No

Have you had any problems with local anesthetics such as Novocain or Lidocaine? Yes No

Do you take a blood thinner such as Aspirin or Coumadin? Yes No If yes, why?_____

What medications do you take regularly? _____

_____

If you are not sure of a drug name tell the Doctor about the drugs you take.

GENERAL HEALTH

Do you smoke? Yes No

Do you drink alcohol or wine? Yes No If yes: (1-2 drinks per day) (1-2 per week) (1-2 per month)

Do you have Diabetes? Yes No If yes: # of years_____If yes: Do you take insulin: Yes No

Have you had any serious illnesses? Yes No Have you had any major surgeries? Yes No

PERSONAL PHYSICIAN

Are you under a physician's care? Yes No If yes, for what condition? _____

Do you have a personal physician? Yes No If yes, date last seen _____

Have you seen other doctors in the past year? Yes No, If yes, for what? _____

Have you seen another podiatrist in the past year? Yes No

May we contact your doctors about your health? Yes No

Confidential Patient Medical Information (Continued)

Circle any of the following you have or have had a problem with

Heart	Asthma	Skin	Unexplained weight loss
Circulation	Stomach ulcers	Gout	Frequent infections
High blood sugar	Hormones	Tuberculosis	Healing
High blood pressure	Anemia	Rheumatic Fever	Neurological disorder
Stroke	Bladder	Liver	Intestines
Cancer	Kidneys	Arthritis/Gout	Lungs

Do you have any artificial joints? Yes No If yes: Hip Knee Other

Do you have a heart valve implant? Yes No

Do you take antibiotics when you visit the dentist? Yes No If yes, why?_____

Family History

Mother: Living Deceased Cause of death _____

Father: Living Deceased Cause of death _____

Brother: Living Deceased Cause of death _____

Sister: Living Deceased Cause of death_____

Employment

Job status: Employed Not employed Retired

At work do you mostly: Sit Stand Both standing & walking

END

Thank you

Dr. Florence Ouska-Griffin