MEDICAL INFORMATION

This information is important For Our Records And Your Heath

Please Print Your Name:_____

Describe your foot /ankle problem:_____

_____

_____

How long has it been bothering you? Number of Days_____ Or weeks_____ Or years_____

Describe past **treatment** for your feet /ankles?_____

_____

Describe past medication /injections for problem:_____

Describe past surgery of your feet and ankles?_____

_____

MEDICATIONS

Are you allergic or sensitive to medication? Yes No Antibiotics **(circle)** Penicillin Sulfa drugs
Other medication allergies: Name:_____
Alleric to? Betadine(iodine): Yes No
Have you had **problems** taking **aspirin or ibuprofen (Advil, Motrin)**? Yes No
Have you had any **problem** with **local anesthetics (Novocaine, Lidocaine)**? Yes No
What medications do you take regularly? Name:_____

_____

Do you take a **blood thinner**? Yes No Aspirin or Coumadin? Why_____
If you are not sure of a drug name please tell the doctor about any drugs you take.

GENERAL HEALTH

Do you have **Diabetes**?: Yes No # 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

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

_____

Family physician name:_____Date last seen: _____

Have you seen any other doctors recently? Yes No Another podiatrist? Yes No

May we contact your doctors about your health? Yes No

_____

Dr. Florence T. Ouska-Griffin

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

Heart	Asthma	Skin	Unexpiained 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 Hip Knee
Do you have a heart valve implant? Yes No
Do you take antibiotics when you go to the dentist? Yes No 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 _____

Is there a family history of: **(Circle all that apply)**
Heart Disease Diabetes Bleeding disorder Gout Bunions Flatfeet Circulation problems

HABITS

Do you smoke? Yes No If yes, list the packs per day _____ Years_____

Do you drink alcohol, wine or beer? Yes No (1-2 drinks per day) (1-2 per week) (1-2 per month)

EMPLOYMENT

Job Status: Employed Not employed Retired
At work do you: Mostly sit, Mostly stand, Do both standing & walking

Thank You, Please sign below confirming that all the information is true to the best of your knowledge.

Signature _____ **Date** _____