Podiatry Medical History Form

Today's Date:_____

Full Name:_____Date of Birth:_____

Do you have any of the following medical problems (circle any that apply)?

Hypertension	Asthma	Osteoporosis	Sleep Apnea
High Cholesterol	Cancer:_____	DVT/PE	Ulcerative Colitis
Diabetes TYPE:____	Psoriasis	Ankylosing Spondylitis	Rheumatoid Arthritis
Bleeding Disorder	Heart Disease	Ulcers/Acid Reflux	Hepatitis
Hypothyroidism	Kidney Disease	Gout	Headaches
Joint Pain	Breathing Issues	Vision Issues	Bleeding Problems
Skin Problems	Numbness/Tingling	Dizziness	Fever/Chills
Hearing Problems	Difficulty Urinating	Constipation	Other:_____

List any surgeries and dates:

_____

_____

Have you ever had problems with anesthesia (if yes, please explain)? Yes No

_____

Do you have a history of a metal allergy (if yes, please explain)? Yes No

_____

Do you have any medication allergies (circle any that apply)?

NONE PENICILLIN SULFA MORPHINE CODIENE ASPIRIN ADHESIVE TAPE LATEX

Other:_____

Are there any medical problems in your family (if so circle and which relative)

Hypertension	Lupus	Osteoporosis	Sleep Apnea	High Cholesterol
Colon Cancer	DVT/PE	Ulcerative Colitis	Diabetes	Breast Cancer
Psoriasis	Ankylosing Spondylitis	Rheumatoid Arthritis	Prostate Cancer	Heart Disease
Ulcers/Acid Reflux	Hepatitis	Lung Cancer	Kidney Disease	Leukemia/Lymphoma
Asthma	Gout	Hypothyroidism	Bleeding Disorder	Other:_____

Do you use tobacco (circle any that apply)? No Yes

Snuff/Chew Cigar/Pipe Cigarettes Former Smoker

Do you drink alcohol (circle any that apply)? No Yes

Daily Weekly Monthly or less

What do you do for work?

Retired Career Type:_____

Do you take any calcium supplements (circle any that apply)? No Yes

Fosamax Calcium Pills (Citracal) Tums Viactiv

Are you taking any Herbal Medicines or Blood Thinners (circle any that apply)? No Yes

Herbal:_____ Coumadin Plavix/Aspirin NSAIDs