FOOT HEALTHCARE ASSOCIATES

DR.NEAL MOZEN * DR. MODUPÉ ADERIBIGBE * DR. GARY DOCKS
DR. STEPHANIE MARTIN * DR. BRYAN WEST * DR. LAAL ZADA

PHYSICIAN-SURGEONS OF THE FOOT AND ANKLE

BRIEF MEDICAL HISTORY FORM DATE_____________

(Please print and complete as fully as possible)

PATIENT'S NAME____

WHAT IS YOUR FOOT PROBLEM? ____

____

____

WHEN DID THIS PROBLEM START? ____

HAVE YOU HAD FOOT TREATMENT BEFORE?________________ IF YES, BY WHOM AND WHAT KIND___

____

HAVE YOU TREATED THIS PROBLEM AT HOME? ____

HAVE YOU INJURED YOUR FEET BEFORE/IF SO, HOW?____

____

WHAT KIND OF WORK DO YOU DO? ____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST YOU CAN:

YOUR: HEIGHT____ WEIGHT____ SHOE SIZE____

ARE YOU IN: ( ) GOOD HEALTH ( ) FAIR HEALTH ( ) POOR HEALTH

ARE YOU SUBJECT TO PROLONGED BLEEDING OR HEALING DIFFICULTIES?_____________________________

____

ARE YOU UNDER THE CARE OF A DOCTOR? ( ) YES ( ) NO IF YES, STATE THE REASON___________

____

____

PHYSICIAN'S NAME AND ADDRESS ____

WHEN WAS THE LAST TIME YOU SAW A DOCTOR? _____________________________________

WHEN WAS THE LAST TIME YOU HAD A "COMPLETE" CHECK-UP? _____________________________________

WHAT MEDICATIONS ARE YOU TAKING? ____

____

ARE YOU PREGNANT? ( ) YES ( ) NO LAST MENSTRUAL PERIOD____

DO YOU EXERCISE: ( ) YES ( ) NO IF YES, HOW MUCH? ____

DO YOU SMOKE? ( ) YES ( ) NO IF YES, HOW MUCH? HOW LONG? ___________________________________

IF YOU QUIT, WHEN DID YOU QUIT?_____________ HOW LONG DID YOU SMOKE?________________

Alcoholic beverages (including beer and wine): How many drinks per day? ___________________________________

Do you use illicit drugs such as marijuana, cocaine… ( ) YES ( ) NO Explain __________________________________

____

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( ) I AM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE
( ) I AM ALLERGIC TO (PLEASE CHECK)

___ASPRIN	___MERCURIALS	___SUTURES
___LIDOCAINE	___MERTHIOLATE	___OTHER
___CODEINE	___IODINE	_________________________
___DEMEROL	___ADHESIVES/TAPE	_________________________
___PENICILLIN	___NYLON,PLASTICS	_________________________
___SULFA	___ANTIHISTAMINES	_________________________

EXPLAIN THE TYPE OF "ALLERGIC" REACTION YOU HAVE TO ANY OF THE ABOVE:

____

I HAVE OR HAVE HAD THE FOLLOWING (PLEASE CHECK):

___DIABETES	___ASTHMA	___VENEREAL DISEASE
___BLEEDING TENDENCIES	___CANCER	___ANEMIA
___EPILEPSY	___GLAUCOMA	___TUMORS
___HEART TROUBLE	___KIDNEY TROUBLE	___GOUT
___NERVOUSNESS	___ARTHRITIS	___HIGH BLOOD PRESSURE
___STROKE	___TUBERCULOSIS	___STOMACH ULCERS
___VARICOSE VEINS	___LEG CRAMPS	___POLIO
___HEPATITIS	___HIV-AIDS	___ARTERIOSCLEROSIS
___LOW BACK PAIN	___BLOOD CLOTS	___**JOINT REPLACEMENT**

FURTHUR EXPLAIN ANY OF THE ABOVE CONDITIONS YOU HAVE HAD______________________

____

HAVE ANY OF YOUR FAMILY MEMBERS HAD DIABETES OR OTHER SERIOUS CONDITIONS?___

____

PLEASE LIST ALL OF THE HOSPITALIZATIONS AND SURGERIES YOU HAVE HAD________________

____

____

IS THERE ANYTHING ELSE WE SHOULD KNOW?______________________________________

____

_________________________	_______________________________________
DATE	SIGNATURE OF PATIENT
_____________________________________	_______________________________________
PERSON GIVING INFORMATION/RELATION	PARENT OR GUARDIAN

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