MEDICAL HISTORY

Name of Physician: Address of Physician:

Physician's Phone Number: Are You Currently Under Your Physician's Care? _____Yes _____No

If Yes, For What?: May We Contact Your Physician For Your Health Records? _____Yes _____No

List Any Medical Conditions You May Have (Allergies, Impairments, Etc.)

List All Medications You Are Currently Taking:

If Diabetic, Are You Insulin Dependent? _____Yes _____No Date Last Seen By Physician For Diabetes:

My Chief Foot Complaint Is: This Condition Has Existed For: ____Days ____Weeks ____Months ____Years

Is This Condition Due To Accident or Injury? ____Yes ____No Is Injury Job-Related? ____Yes ____No Explain:

Have You Had Previous Treatment by a Podiatrist? ____Yes ____No When? Reason:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (DNK indicates DO NOT KNOW)

	YES	NO	DNK
Foot or Leg Injuries	☐	☐	☐
Foot or Leg Surgery	☐	☐	☐
Foot or Leg Cramps	☐	☐	☐
Foot or Leg Numbness	☐	☐	☐
Knee Pain	☐	☐	☐
Unequal Leg Length	☐	☐	☐
Weak Ankles	☐	☐	☐
Bunions	☐	☐	☐
Foot Skin Problems	☐	☐	☐
Toe Nail Problems	☐	☐	☐
Low Back Pain	☐	☐	☐

	YES	NO	DNK
Diabetes	☐	☐	☐
Heart Trouble	☐	☐	☐
Epilepsy	☐	☐	☐
Liver Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Rheumatic Fever	☐	☐	☐
High Blood Pressure	☐	☐	☐
Polio	☐	☐	☐
Bursitis	☐	☐	☐
Stomach Ulcers	☐	☐	☐
Asthma	☐	☐	☐

	YES	NO	DNK
Anemia	☐	☐	☐
Gout	☐	☐	☐
Fainting Spells	☐	☐	☐
Bleeder	☐	☐	☐
Blood Disease	☐	☐	☐
Circulation Problems	☐	☐	☐
Hardening of Arteries	☐	☐	☐
Varicose Veins	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Prone To Infection	☐	☐	☐

ALLERGIES

	YES	NO	DNK
Novocaine	☐	☐	☐
Penicillin	☐	☐	☐
Sulfa	☐	☐	☐
Adhesive Tape	☐	☐	☐
Materials	☐	☐	☐
Drugs	☐	☐	☐
Foods	☐	☐	☐

Other (Describe Below)

_____

_____

_____

I have received written information as an introduction to this facility and its doctors.

I hereby give ANKLE & FOOT SPECIALISTS permission to examine and treat my feet.

Patient's, Parent's, or Guardian's Signature _____ Date _____

I request that payment of authorized _____ benefits be made on my behalf to
(INSURANCE COMPANY)
ANKLE & FOOT SPECIALISTS for any services furnished me by that physician/supplier. I authorize any holder of Medical information about me to release to _____ any information needed to determine
(INSURANCE COMPANY)
these benefits or the benefits payable for related services.

_____ _____

Patient's, Parent's, or Guardian's Signature Date