



PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ Height: _____ Weight: _____ Shoe Size _____

Current Foot or Ankle problem: _____

When did the problem start? _____

What has been done to treat the problem? _____

Are you now or have you ever been under a physician's care in the past two years? _____

If yes, please explain: _____

Family Physician Name: _____ Date last seen: _____

Address / Phone number: _____

Name of Former Podiatrist/Foot & Ankle Specialist: _____ Date last seen: _____

What condition(s) were you treated for: _____

MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney (Renal) or Bladder diseases | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Heart/Coronary Artery Disease | <input type="checkbox"/> Anemia (low Fe/sickle cell) | <input type="checkbox"/> Depression or Anxiety |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Asthma / Bronchitis | <input type="checkbox"/> Vascular / Circulatory Disease |
| <input type="checkbox"/> Stroke (CVA) or Heart Attack | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Stomach Ulcer / Reflux | <input type="checkbox"/> Accident / Injuries | <input type="checkbox"/> Arthritis (OA/RA/Charcot/etc) |
| <input type="checkbox"/> Hypercholesterol | <input type="checkbox"/> Immunological Diseases | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Liver Disease (ie. Hepatitis) | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Other |

Please explain any positive responses above:

MEDICATIONS (please include dosage of each); Please use back if necessary or Provide attachment list

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____



ALLERGIES. (Penicillin? Sulfa? Codeine? Local anesthesia? Injectable Dye? Tape? Foods? etc.); Please indicate symptom(s)

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

SURGERIES / HOSPITALIZATIONS (describe procedure, year, and any complications); Please use back if necessary

1) _____

2) _____

3) _____

4) _____

PHARMACY PREFERRED

NAME/ADDRESS/PHONE: _____

SOCIAL HISTORY

Occupation: _____ Tobacco: If yes, how much/long? _____

Alcohol: If yes, how much? _____ Illicit drugs: If yes, what kind? _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems, etc.):

FEMALE: Pregnant? Please Circle NO YES How far along? _____

Name and Phone number of Ob/Gyn? _____

Physician Referral? If so, name and info: _____

Other Referring source: () Advertisement, () Family/Friend, () Insurance, () Newspaper, () Phone Book, () Website, () Other

I hereby give ELITE FOOT & ANKLE permission to diagnose and administer treatment for my foot and ankle condition(s) and authorize any release of information obtained in the course of my treatment.

Patient / Guardian Signature: _____ **Date:** _____

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