MEDICAL HISTORY

Reason for today's visit: _____

I have had this problem for: _____ _____ _____
Weeks Months Years

Have you tried any treatment for this problem (include medication)? If yes, explain: _____

_____

Date of injury or accident (if applicable) and brief description: _____

_____

****

List all prescription and over the counter medications: _____

_____

_____

_____

_____

_____

List allergies to medication, food, latex, etc.: _____

_____

List all previous operations and complications: _____

_____

Do you have a medical condition, such as a joint replacement, MVP, etc., that requires antibiotics prior to a procedure? _____

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Circle any of the following that you have or that exist in your family history (mother, father, or siblings):

Foot Problems Diabetes Arthritis Bleeding Problems Healing Problems

Gout Kidney Disease Liver Disease Lung Disease High Blood Pressure

Patient / Guardian Signature: _____ Date: _____