



Comprehensive Foot Care and Surgery

Patient's Name: _____ {First, Last Name} _____ {Date of Birth}

ALLERGIES Do you have any Drug Allergies? __ Yes __ No

Please list ALL food and drug allergies and your reactions to those medications below:

Drug or Food	what kind of Reaction?
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS: Do you currently take any medications? __ Yes __ No

Please list ALL Current medications

Current Medication	
1. _____	2. _____
3. _____	4. _____

Preferred Pharmacy: _____

Pharmacy Address or Telephone number: _____

Tobacco History

- I do not use tobacco products
 I smoke cigarettes I smoke ___ cigarettes per day I smoke ___ packs per day
 I smoke cigars I smoke ___ cigars per day ___ I chew tobacco
 I quit smoking in ____ (year) I used to smoke ___ cigarettes per day; or ___ packs per day.

Alcohol History

- I never drink alcohol I drink most days, ___ drink(s) per day
 I infrequently drink alcohol I quit drinking in ____ (year)
 I drink ___ alcohol beverages per week I have a history of alcohol abuse.

Family History

Mother	Living _____	Deceased _____	Cause of Death _____
Father	Living _____	Deceased _____	Cause of Death _____
Brother	Living _____	Deceased _____	Cause of Death _____
Sister	Living _____	Deceased _____	Cause of Death _____

Is there a family (blood relatives) history of:

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bunions | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Flatfeet | <input type="checkbox"/> Circulation problems in legs or feet |

Do you have any artificial joints? __ yes __ no If, yes where? _____

Do you have a Heart Valve Implant? __ yes __ no

Signature of Patient/Guardian: _____ Date: _____