Medical History **Office use:** **Account #________________** **Insurance______________________**

Patient Name: ____ **Birth Date:**_________________________________

Please describe foot/ankle problem, (please include duration and location)

____

____

Please circle if you have any of the following:

AIDS/HIV
Alcoholism
Alzheimers Disease
Anemia
Anxiety
Arteriosclerosis
Arthritis
Artificial Heart Valve
Artificial Joints
Asthma
Atrial Fibrillation
Back Problems
Bleeding Disorder
Cancer
Carpal Tunnel Syndrome
Cerebral Palsy
Chemical Dependency
Circulatory Problems
Congestive Heart Failure
COPD
Dementia
Depression
Diabetes A1C level____________
Eczema
Electrical Heart Problems
Emphysema
Fibromyalgia
Fracture of foot/ankle
Gout
Heart Conditions/Disease
Hepatitis
High Blood Pressure ____________
Kidney Problems
Liver Disease
Low Blood Pressure
Lupus
Multiple Sclerosis
Muscular Dystrophy
Neuropathy
Parkinson Disease
Polio
Psychiatric Condition
Radiation/Chemo Therapy
Respiratory Disease
Restless Leg Syndrome
Rheumatic Fever
Sarcoidosis
Scarlet Fever
Scoliosis
Seizures
Sleep Apnea
Stomach Ulcer
Stroke
Thyroid Disorders
Tuberculosis
Varicose Veins
Other: _________________
____
____
____
____
____
____
____
____
____

Past Surgical History/Complications:

____
____
____
____
____
____

Family History:
Please check if applicable:

___	Bleeding Disorder	___ Mother	___ Father
___	Blood Clots	___ Mother	___ Father
___	Cancer	___ Mother	___ Father
___	Diabetes	___ Mother	___ Father

___ Other ____

Medications:
Please list all prescriptions, over the counter Medications, and dosages (if known) and any Changes since last visit

____
____
____
____
____

Allergies:
Please circle if you have an allergy to the listed medication and list the reaction to the medication.

NO ALLERGIES
Anesthetics _____________
Adhesive Tape ___________
Aspirin _________________
Codeine ________________
Latex __________________
Penicillin ________________
Sulfa ___________________
Tetanus __________________
Other __________________
____
____

Have you had the Pneumonia Vaccine? No Yes

Have you had a Flu Vaccine No Yes

Have you been discharged from a Hospital or Rehabilitation Facility within 30 days? No Yes

Pharmacy Name/Phone _________________________

Smoker? No Yes **Have you ever smoked?** No Yes
Do you drink alcohol? No Yes
Height _____ **Weight** _____ **Shoe Size** _____ **Blood Pressure** _________

I certify that all above information is true and correct to the best of my knowledge. I give my permission to physicians and staff at the Spokane Foot Clinic and Northwest Surgery Center to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem.

Signature of patient:____**Date:_________________**

Signature of parent or legal guardian:____**Date:_________________**