Medical History 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:**_____

Rev 2/23/2016