

PODIATRIC REGISTRATION AND HISTORY



MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack (when: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning in Feet / Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol abuse History	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse History	<input type="checkbox"/> Yes <input type="checkbox"/> No	→ What kind: _____		Liver Disease (Hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina (chest pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints (which: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet (kind: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke or Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles/Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
→ Explain: _____		Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots (DVT's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble (Murmur)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have not had Surgery before

Please List Surgeries you have had (include approximate year):

I have NOT had complications with Anesthesia from previous surgeries

Please list hospitalizations other than for surgeries listed above: _____

Family physician _____ Date of last visit _____

Are you now or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

Is there any chance that you could be pregnant now? Yes No

Tobacco Use: Never Cigarettes Quit Date _____ **Current Smoker:** Packs/day? _____ # of years? _____

Other Tobacco: Pipe Cigar Chew **Alcohol use:** No Yes → # of Drinks/week of: beer ___ wine ___ hard alcohol ___

MEDICATIONS

Indicate prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

ALLERGIES

I do NOT have any drug allergies

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Iodine	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Seafood	<input type="checkbox"/> Demerol
<input type="checkbox"/> Local Anesthetic (Novocaine)	<input type="checkbox"/> Adhesive Tape
	<input type="checkbox"/> Sulfa

Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, or medical conditions affecting my feet.

Patient (or guardian) signature _____ Date _____