MEDICAL HISTORY

This complete record is confidential.

Patient's Name: Last: First: Middle:		Date of Birth: _____ MALE FEMALE
Name of Primary Physician:	Primary Physician Phone number:	May we contact your primary physician for your health records? ☐Yes ☐ No Date Last Seen: _____
Former podiatrist name:	Former podiatrist phone number:	May we contact your former podiatrist for records?
If any, what kind of podiatric treatment did you have?		When did you have this treatment?
Major foot complaint today is?		
This condition(s) has existed for ____days ____weeks ____months ____ years		Height: ____ft. ____in. Weight:_____ Shoe Size: _____

Check any of the following conditions below that you currently have or have been treated for in the past:

☐ ***NONE***

	Diabetes
	Leg or feet injuries/surgeries
	Bleeding Tendencies
	Leg Cramps
	Heart Problems
	Asthma
	Epilepsy

	Rheumatic Fever
	Kidney Problems
	Liver Problems
	Arthritis
	Bursitis
	High Blood Pressure
	Low Blood Pressure

Any other conditions not listed above, please specify?

Check any Existing Allergies: ☐ No Known Allergies ☐Novocain ☐Penicillin ☐Sulfa Drugs ☐Adhesive Tape

☐Latex ☐Other: *please specify?* _____

Do you take any medicines regularly? Yes or No: *please list*_____

_____

Pharmacy Name: _____ Pharmacy address: _____

	YES	NO	Comment
Do you use alcohol? If yes, how much?			
Do you smoke? If yes, how much?			
Do you use caffeine? If yes, how much?			
Have any family members been treated for diabetes?			
Have you had any injuries or surgeries on your feet or legs?			

ePrescribing software sends prescriptions over the internet to your pharmacy safely and securely. ePrescribing software helps protect your personal information while allowing your provider to access important data such as drug interactions and prescription history.
I agree that Allied Ankle & Foot Care Centers, PC may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.
By signing below, I acknowledge that I have read and understand all of the above.

Preferred Notification Method for Preventive Health Reminders: ☐E-Mail ☐Text Message ☐Phone ☐Postal Mail
Email: _____

Primary Language Spoken (Required):_____

I hereby give Allied Ankle & Foot Care Centers, P.C. permission to examine and to provide treatment.

Patient Signature_____ Date_____