

# PATIENT MEDICAL HISTORY

**WHO IS YOUR PERSONAL PHYSICIAN?** \_\_\_\_\_

**PHARMACY:** *(Name, address, city)* \_\_\_\_\_

**HOW IS YOUR GENERAL HEALTH?** \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** \_\_\_\_\_

**LIST OF SURGERIES:** \_\_\_\_\_

**ARE YOU DIABETIC?***(Circle)* Yes No **DO YOU SMOKE?***(Circle)* Yes No **DO YOU DRINK ALCOHOL?***(Circle)* Yes No

**Please list any medical problems:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **MEDICATIONS**

**Please list any medications or drugs you take:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **ALLERGIES**

**Please list any medications that you are allergic to:** \_\_\_\_\_  
\_\_\_\_\_

## **PODIATRIC HISTORY**

**WHAT IS THE REASON FOR THE VISIT?** \_\_\_\_\_

**HOW LONG HAVE YOU HAD THIS CONDITION?** \_\_\_\_\_

**HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE?***(Circle)* Yes No

**DOCTOR'S NAME:** \_\_\_\_\_

**LAST VISIT:** \_\_\_\_\_

**HAVE YOU HAD PREVIOUS FOOT SURGERY?***(Circle)* Yes No \_\_\_\_\_

**Please indicate which foot problems you have had in the past:** \_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge. I give permission to Jeff Brooks, DPM or Andrew To, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet (or that of y minor child or dependent).

Print name \_\_\_\_\_

Patient signature \_\_\_\_\_

Date: \_\_\_\_\_

Legal Guardian (if patient is a minor) \_\_\_\_\_

Date: \_\_\_\_\_