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
Former podiatrist name	Former podiatrist phone number	May we contact your former podiatrist for records? ___ Yes ___No
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		Is your foot condition: Due to an injury? _____ Due to a motor vehicle accident? _____ Due to an injury at your workplace? _____

Check any of the following below that you have or have been treated for:

- ☐ Diabetes- Insulin_____ Non Insulin_____
- ☐ Prior _____ Recent_____Feet or Leg injuries?
- ☐ Prior _____ Recent ___ Feet or legs surgeries?
- ☐ Bleeding Tendencies/ Blood Clots/ Leg Cramps
- ☐ Heart Problems
- ☐ Asthma
- ☐ Epilepsy/Seizures? If so, When?_____
- ☐ TIA/Stroke? If so, When? _____
- ☐ Skin Disease _____
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Arthritis? Where _____
- ☐ Bursitis
- ☐ High Blood Pressure or Cholesterol
- ☐ Cancer? Where_____Treatment?_____
- ☐ Other-what?

Check any existing allergies: ☐Novocaine ☐Penicillin ☐Sulfa Drugs ☐Adhesive Tape
☐Latex ☐Other—Please specify: Metal? Seasonal? Food?_____
☐ No Known Allergies

What medicines do you take regularly?

	YES	NO	If Yes, How much?
Do you use alcohol? Never___ Former ____ Current ____			
Do you smoke tobacco? Never___ Former ____ Current ____			
Do you use caffeine? If yes, how much?			
Are you currently taking any blood thinners?			If so, Which one? _____
Please list Family History of any of the above medical problems			

Pharmacy Name: _____ Address or Phone Number: _____

Height: _____ Weight:_____ Shoe Size: _____

Preferred Notification Method for Preventive Health Reminders: ☐Web Message ☐Phone ☐Mail

Primary Language Spoken (Required):_____

I hereby give Instep Podiatry, LLC permission to examine and to provide treatment.

Patient's Signature_____Date_____