COMPLETE THIS SIDE ONLY

PATIENT HISTORY

DATE:____________

AGE: ____________ SEX:____________ HEIGHT:____________ WEIGHT:____________

HAS THERE BEEN ANY CHANGE IN YOUR HEALTH WITHIN THE PAST YEAR? YES____ NO____

DATE OF LAST PHYSICAL EXAMINATION: ____________

A: NAME OF YOUR PHYSICIAN: ____________

B: ADDRESS:____________ PHONE NO: ____________

C: ARE YOU NOW UNDER HIS/HER CARE? YES____ NO____

ARE YOU BEING TREATED FOR ANY OTHER CONDITIONS? YES____ NO____

IF YES, PLEASE EXPLAIN:____________

HAVE YOU BEEN HOSPITALIZED OR HAD A SEVERE ILLNESS WITHIN THE PAST FIVE YEARS? YES____ NO____ IF YES, WHAT WAS THE PROBLEM? ____________

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:

YES NO A: LOCAL ANESTHETICS (NOVOCAINE)
YES NO B: PENICILLIN OR OTHER ANTIBIOTICS
YES NO C: TRANQUILIZERS OR SLEEPING PILLS
YES NO D: CODEINE OR OTHER PAIN MEDICATION
YES NO E: ASPIRIN
YES NO F: OTHER (PLEASE BE SPECIFIC):____________

HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY, CUTS, OR TRAUMA? YES____ NO____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

YES NO A: RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE
YES NO B: ABNORMAL HEART CONDITION - IF YES, PLEASE EXPLAIN: ____________
____
YES NO C: ABNORMAL BLOOD PRESSURE - IF YES, HIGH: ________ LOW:________
YES NO D: ALLERGIES (OTHER THAN MEDICATIONS)
YES NO E: SINUS CONDITION
YES NO F: HIVES OR SKIN RASH
YES NO G: FAINTING SPELLS
YES NO H: SEIZURES (EPILEPSY)
YES NO I: DIABETES OR A HISTORY OF DIABETES IN THE FAMILY
YES NO J: HEPATITIS, JAUNDICE OR LIVER DISEASE
YES NO K: RHEUMATOID ARTHRITIS (PAINFUL, SWOLLEN JOINTS)
YES NO L: STOMACH ULCERS
YES NO M: KIDNEY DISORDERS
YES NO N: VENEREAL DISEASE
YES NO O: ANEMIA
YES NO P: HISTORY OF CANCER
YES NO Q: OTHER (PLEASE EXPLAIN): ____________

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

YES NO A: ANTIBIOTICS
YES NO B: BLOOD THINNER (ANTICOAGULANTS)
YES NO C: MEDICINE FOR HIGH BLOOD PRESSURE
YES NO D: WATER PILLS (DIURETICS)
YES NO E: CORTISONE (STEROIDS)
YES NO F: TRANQUILIZERS
YES NO G: ANTIHISTAMINES
YES NO H: ASPIRIN OR TYLENOL
YES NO I: INSULIN OR OTHER MEDICATIONS FOR DIABETES
YES NO J: INDERAL, DIGITALIS OR OTHER MEDICATION FOR HEART TROUBLE
YES NO K: NITROGLYCERIN
YES NO L: OTHER (PLEASE BE SPECIFIC):____________

DO YOU GET FREQUENT LEG CRAMPS OR NUMBNESS IN YOUR FEET/TOES: YES____ NO____

IF A WOMAN, ARE YOU PREGNANT? YES____ NO____

ARE YOU A SMOKER? YES____ NO____

WHAT IS YOUR CHIEF FOOT/ANKLE COMPLAINT? (DESCRIBE): ____________

____

____

SIGNATURE OF PATIENT: ____________