Patient Information and Health Record

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How were you referred to this office?

_____

Please describe your foot problem:

_____

Have you ever had previous foot care or surgery? YES/ With Whom_____ NO_____

Pharmacy Name, Address and Number

_____

_____

GENERAL HEALTH **Height: _____ Weight:_____ AGE: _____**

	Anemia		**Hypertension (HBP)**
	Arthritis		**HIV / AIDS**
	Asthma		**Liver Disease (Hepatitis)**
	Cancer (type)		**Mental Disease (Anxiety, Depression, etc.)**
	Cardiac Disease		**MRSA/ VRE**
	Cerebral Accidents (stroke)		**Peripheral Vascular Disease**
	Cholesterol		**Phlebitis / Thrombosis**
	Diabetes		**Polio, Cerebral Palsy, Muscular Dystrophy**
	Emphysema		**Renal Disease**
	Epilepsy		**Thyroid**
	Glaucoma / Eye		**Tuberculosis**
	Gout		**Venereal Disease**
Other:			

Do you Drink? YES_____ NO_____ If YES, how many drinks pre week _____

Do you smoke? YES _____ NO _____ Former____ If YES, Cigars/ Cigarettes How much daily? _____

ALLERGIES:

	Adhesive Tape		**Cortisone**		**Novocain**
	Aspirin		**Environmental**		**Penicillin**
	Barbiturates		**Foods (list)**		**Sulfa Drugs**

	NSAIDS		**Iodine Dyes**		**Tetracycline**
	Codeine		**Latex**		**Other (list)**

Are you taking medication? YES _____ NO _____

If YES, please list:

_____

Are you under a Doctor's care at this time? YES _____ NO _____

Have you had previous Surgery? If YES, please list

_____