FOOT & ANKLE PHYSICIANS & SURGEONS
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PRINT NAME _____ DATE _____

DATE UPDATED _____ INITIAL_____

PATIENT MEDICAL HISTORY

Describe your problem: _____

_____

How long has it been bothering you? _____ **Family Physician:** _____

MEDICATIONS

List medications you take regularly: *(continue on back side if needed)* □ *Check here if you take* ***no medication***

_____ _____ _____

_____ _____ _____

List medications you are allergic or sensitive to: □ *Check here if none*

Antibiotics (Penicillin, Sulfa, etc) _____

Other Medicines _____

Any problems with local anesthetics (Novocaine, Lidocaine)? □ Yes □ No / Betadine (Iodine)? □ Yes □ No
Medical Tape? □ Yes □ No / Aspirin, Ibuprofen (Advil, Motrin)? □ Yes □ No / Latex? □ Yes □ No

Social History: Tobacco Use? □ Yes □ No □ Past / Alcohol Use? □ Yes □ No / Illicit Drug Use? □ Yes □ No

Do you have or have you ever had: *(please circle)* Cancer / COPD / Diabetes / Heart Disease / Hepatitis A, B, or C / High Cholesterol / High Blood Pressure / Kidney Disease / Other: _____

_____

List all surgeries you have had: _____

_____

REVIEW OF SYSTEMS *(to be completed by office staff only)*

Height _____ Weight _____ BP _____ Pulse _____ Respirations _____ Temp _____
Are you currently pregnant? □ Yes □ No Race _____ Ethnicity _____ Language _____

Findings: [√] Normal [+] Abnormal

General		Abdominal	
Eyes		Lymph	
ENT		Genitourinary	
Respiratory		Musculoskeletal	
Cardiovascular		Skin	
Chest/Breast		Neurological	
Neck		GI	

Details of abnormal findings

_____

_____

_____

_____

_____

_____

_____

_____ _____
Corey B Russell, DPM / Michael J Walkovich, DPM *Date*
Theodore H Bowlus, DPM