Medical information

Primary Care Physician: _____ **Address:** _____

Date of Last Visit w/ PCP: _____ **Phone :** _____

Do you have a history of: High Blood Pressure Stomach Problems Kidney Problems Heart Problems

Gout Diabetes (Insulin or Non Insulin) Stroke Arthritis Hepatitis HIV Positive Tuberculosis Anxiety

Other Disease(s) not mentioned: _____

Patient Medications: _____

_____

Allergies to Medicine: Local Anesthesia Aspirin Penicillin Codeine Morphine Other: _____

Previous Surgeries & Dates: _____

Family History of: Heart Problems Diabetes Cancer

HEALTH QUESTIONNAIRE

Please circle yes or no

Do you have numbness and tingling in your feet or hands?	yes	no
Do you have leg pain after walking several blocks that is relieved with rest?	yes	no
Do you limit your activities because of foot pain?	yes	no
Females: Are you pregnant?	yes	no
Do you have any medical concerns not listed that you wish to discuss?	yes	no

What is your foot and/or leg complaint today? _____

_____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____

Print Name of Patient, Parent or Guardian | Signature of Patient or Guardian | Date