PATIENT MEDICAL HISTORY

WHO IS YOUR PERSONAL PHYSICIAN?_____
PHARMACY: (*Name, address, city*)_____
HOW IS YOUR GENERAL HEALTH? _____ **HEIGHT:** _____ **WEIGHT:** _____
FAMILY MEDICAL HISTORY:_____
LIST OF SURGERIES:_____
ARE YOU DIABETIC?(*Circle*) Yes No **DO YOU SMOKE?**(*Circle*) Yes No **DO YOU DRINK ALCOHOL?**(*Circle*) Yes No

Please list any medical problems:_____

_____

_____

MEDICATIONS

Please list any medications or drugs you take:_____

_____

_____

ALLERGIES

Please list any medications that you are allergic to:_____

_____

PODIATRIC HISTORY

WHAT IS THE REASON FOR THE VISIT?_____

HOW LONG HAVE YOU HAD THIS CONDITION?_____

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE?(Circle) Yes No

DOCTOR'S NAME:_____ **LAST VISIT:**_____

HAVE YOU HAD PREVIOUS FOOT SURGERY?(*Circle*) Yes No _____

Please indicate which foot problems you have had in the past: _____

_____

I certify that the above information is true and correct to the best of my knowledge. I give permission to Jeff Brooks, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet (or that of y minor child or dependent).

Print name_____

Patient signature _____ Date: _____

Legal Guardian (if patient is a minor) _____ Date: _____