ANKLE & FOOT
ASSOCIATES, LLC

Patient Medical History

What is the primary reason for your visit today: _____

_____

Family Doctor: _____ **Date Last Seen:** _____

Which LOCAL Pharmacy do you use: _____

Do you smoke? ☐ No ☐ Yes How much? _____ Drink Alcohol? ☐ No ☐ Yes How much? _____

Is there a family history of: Heart Disease _____ Cancer _____ or Diabetes _____

Do you exercise on a regular basis? ☐ No ☐ Yes

Shoe Size: _____ Weight: _____ Height: _____

Do you take regular medications? ☐ No ☐ Yes; *If Yes, please list on the attached form.*

Are you allergic to any medications? ☐ No ☐ Yes; *If Yes, please list on the attached form.*

Please list all previous surgeries and dates: _____

_____

_____

Please list any other problems for which you have a physician that we should be aware of: _____

_____

_____

PLEASE CHECK ALL THAT APPLY

____Diabetes Type I or II
____Hepatitis
____Stomach Ulcers/Hernia
____Chronic Cough/Wheezing/Asthma
____High Cholesterol
____COPD
____Tuberculosis
____Kidney Stones or Infections
____Are you on Blood Thinners?
____Anemia
____Bleeding or clotting problems

_____Heart Disease
_____High Blood Pressure
_____Heart Attack
_____Seizures
_____Arthritis
_____Thyroid Problems
_____Depression/Bipolar
_____Cancer
_____HIV/AIDS
_____Headaches
_____Stroke

Print Name: _____ ***Date:*** _____