JENNIFER WOO, DPM
Podiatric Medicine & Surgery

Patient Medical History Form

Patient Name: _____

Podiatric History

What is the **chief complaint** for which you have come to be treated? (Include foot, toes, ankle, knees, and hip complaints.)

_____

_____

_____

Have you ever been **under the care of a Podiatrist before**?

☐ Yes ☐ No

If Yes,

Name _____

Last Visit _____

Please indicate if you **now have** or **have had problems** with any of these by marking an "**X**".

___ Ankle pain
___ Athlete's foot
___ Bunions
___ Corns and calluses
___ Cramps in feet or legs
___ Flat feet
___ Heel pain
___ Ingrown toenails
___ Injuries to the foot
___ Plantar warts
___ Swelling in ankles or feet
___ Tired feet

Your **shoe size** _____

Athletic activities in which you participate (please list and indicate frequency):

_____

_____

List **surgeries**, **serious injuries,** and **serious illnesses:**

_____

_____

_____

_____

_____

Allergies and Medications

Allergies and Drug Intolerance

☐ No known drug allergies

☐ Adhesive/Tape
☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local anesthetics (e.g., Novocaine)
☐ Penicillin
☐ Seafood
☐ Sulfa
☐ _____

Medications you are taking (prescription, non-prescription, herbal supplements, vitamins, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please go to the next page.

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Patient Medical History Form

General Medical History

Your **occupation** _____

Your **height** _____

Your **weight** _____

Do you **smoke**?
☐ Yes ☐ No

Have you **ever smoked**?
☐ Yes ☐ No
How much? _____ packs / _____
Years smoked _____

Drink **alcohol**?
☐ Yes ☐ No
How much? _____

Recreational drugs?
☐ Yes ☐ No
What? _____

Pregnant or possibly pregnant?
☐ Yes ☐ No

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Anemia	
___	Arthritis	___
	Type: _____	
___	Artificial heart valves	
___	Artificial joints	
___	Asthma	___
___	Back problems	
___	Bleed easily	___
___	Cancer	___
___	Chemical dependency	___
___	Chest pain	___
___	Circulatory problems	___
___	Diabetes	___
___	Deep vein thromboses	___
___	Epilepsy	___
___	Fibromyalgia	
___	Gout	
___	Heart disease	___

Please indicate if **you** or a **family member now have or have had** any of the following by marking an "**X**".

	You	**Family Member**
___	Heartburn, chronic	___
___	Hemophilia	___
___	Hepatitis	
___	High blood pressure	___
___	HIV/AIDS	
___	Kidney problems	___
___	Liver disease	___
___	Lung/respiratory disease	___
___	Mental illness	___
___	Phlebitis	___
___	Psoriasis	___
___	Rheumatic fever	
___	Stroke	___
___	Thyroid problem	
___	Tuberculosis	
___	Ulcers, stomach	
___	Varicose veins	
___	Venereal disease	

I certify that the above information is correct to the best of my knowledge. I give my permission to the attending physician(s) to administer and perform such procedures as may be deemed necessary for my diagnosis and treatment.

_____ Date

_____ Signature of Responsible Party

_____ Relationship, if not Patient

_____ Printed Name of Responsible Party