Palmetto Podiatry
ROPER ST. FRANCIS PHYSICIANS

Name:_____ Today's Date:_____

MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following conditions?

Yes___ No___ Alzheimer's/ Dementia Disease
Yes___ No___ Arthritis (Painful, swollen joints) what body part:_____ Rheumatoid Yes / No
Yes___ No___ Bleeding Tendencies with surgery or cuts? Do you take Coumadin: Yes / No
Yes___ No___ Cancer; Explain: _____
Yes___ No___ Heart Problems:[Congestive Heart Failure: Yes/ No] [Heart Attack: Yes/ No] [Heart Arrhythmia: Yes/ No]
Yes___ No___ Diabetes [if YES, CIRCLE ONE: Food controlled, Tablet or Insulin]
Yes___ No___ Neurological Problems or Seizures, Explain:_____
Yes___ No___ Hyperlipidema (High Cholesterol)
Yes___ No___ Hypertension: Abnormal Blood Pressure: Circle one: High or Low
Yes___ No___ Kidney Problems: Explain:_____
Yes___ No___ Liver Disease, Hepatitis, Jaundice
Yes___ No___ Neuropathy
Yes___ No___ Poor Circulation
Yes___ No___ Respiratory Conditions (Lung or Breathing Problems) Explain: _____
Yes___ No___ Spine Disorders or Back Pain
Yes___ No___ Stomach or Bowel Problems (If Yes, Explain:_____
Yes___ No___ Stroke Date(s):_____
Yes___ No___ Ulcers of foot or leg (If yes, Explain:_____

Do you have ALLERGIES to any of the following? (Please circle all that apply): Latex Adhesive Tape Aspirin Codeine Iodine Novocaine Penicillin Sulfa NSAID's Percocet Shellfish Other:_____

Do you have a FAMILY HISTORY of any of the following? (Please circle all that apply):
Diabetes: Mother / Father / Brother / Sister
Cancer: Mother / Father / Brother / Sister
Stroke: Mother / Father / Brother / Sister
High Blood Pressure: Mother / Father / Brother / Sister
Heart Problems: Mother / Father / Brother / Sister
Poor Circulation: Mother / Father / Brother / Sister

Please explain your foot problem(s) and how long has it been present? _____
_____

Is your foot problem a result of an accident or injury? Yes___ No___ If yes, please answer the following:
When did the accident/injury occur? (need specific date) _____
Where did the accident/injury occur? _____

Have you ever had any type of SURGERY? If so, please list _____
_____

Do you smoke? Yes_____ No_____ If so, how many packs a day? _____
Do you consume alcoholic beverages? Yes_____ No_____ If so, how much in a week? _____
FEMALES ONLY: Are you pregnant? Yes_____ No_____

Please list all MEDICATIONS you are currently taking, whether they are prescribed or over-the-counter:

_____ _____ _____
_____ _____ _____
_____ _____ _____