Medical History Update

Weight: _____ Height: _____ Shoe Size: _____

Family Doctor: _____ Last Seen: _____

Related to: Work: Yes/ No/ Auto: Yes/ No/ Accident: Yes/ No/ Illness: Yes/ No/ Are you pregnant? Yes/ No/ Maybe

Smoking: Packs/day: _____Years: _____ Past Smoker: Packs/day _____Years: _____Employment requires you to: Sit/Stand/Walk/Not Employed

Caffeine: Quantity _____ Alcohol: None/Rarely/Moderately/Daily/Quit Recreational Drug Use: None/Rarely/Moderately/Daily/Quit

List Athletic activities: _____ Amount per day/week: _____

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints._____
_____
_____

How long have you had pain? ___ Weeks ___ Months ___ Years - On a scale of 1-10 how bad is the pain? 1 2 3 4 5 6 7 8 9 10
Minimal Severe

Who referred you to us? _____

History Of : Do you have or have you ever been treated for: (circled items to indicate YES)

AIDS/HIV	Bunions	Fibromyalgia	Liver Disease	Sinus Problems
Anemia	Chest Pain	Flat Feet	Low Blood Pressure	Special Diet
Angina	Chemical Dependency	Gout	Lung Disease	Sports Related Injuries
Ankle Pain	Cancer	Headaches	Nervous Problems	Stomach Ulcers
Arthritis	Circulatory Problems	Heart Disease	Osteoporosis	Stroke
Artificial Heart Valves	Corns and Calluses	Heel Pain	Phlebitis	Swelling in Ankles/Feet
Artificial Joints	Depression	Hemophilia	Plantar Warts	Tired Feet
Asthma	Diabetes	Hepatitis	Polio	Thyroid Disorder
Athlete's Foot	Ear Problems	High Blood Pressure	Radiation Treatment	Tuberculosis
Back Problems	Eptlepsy	Ingrown Toenails	Rash	Varicose Veins
Bleeding Disorders	Eye Problems	Kidney Problems	Rheumatic Fever	Venereal Disease
Blood Clots	Fainting	Leg Cramps	Seizure Disorders	Weight Loss, unexplained

Family History

List Relationship to you of family members who have had: Foot Problems: _____Arthritis: _____ Cancer: _____

Diabetes: _____ Heart Problems: _____ High Blood Pressure: _____ Other: _____

Past Surgical Procedures/other Hospitalization:

Surgical History & Date | Hospitalization History & Date

_____] [_____

_____] [_____

_____] [_____

_____] [_____

_____] [_____

_____] [_____

Have you previously had a **Blood Transfusions**: Yes/ No Have you previously been exposed to **Hepatitis:** Yes/ No

Medications (please attach additional list if they apply)

Include prescriptions, over-the-counter medications and vitamins: _____

_____

_____

_____

Pharmacy Name: _____ Location: _____ Phone #:_____

Allergies

Are you allergic to any of the following: (circle what applies and note any reactions) or CIRCLE: **No Known Allergies**

Adhesive/Tape: _____ Anticoagulants: _____Aspirin:_____ Codeine: _____ Demerol: _____

Iodine: _____Local Anesthetics: _____ Novocain: _____ Penicillin: _____Seafood: _____ Sulfa: _____

Other: _____

Consent

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment from Michael A, Garvin, DPM, PA.

Print Patient's Name: _____

Representative's Signature: _____ Date: _____