

"We keep you walking, We keep you healthy"



**VICTOR VILLAGONZALO, DPM  
PODIATRIST**

408 EAST UPLAND RD ITHACA, NEW YORK 14850  
TEL: (607) 257-8877 FAX: (607) 257-8879

**MEDICAL INFORMATION FORM**

PLEASE DESCRIBE YOUR FOOT PROBLEM: \_\_\_\_\_

HOW LONG HAS IT BEEN BOTHERING YOU? [ ] Days [ ] Weeks [ ] Months [ ] Years

Any past problems with your feet and/or ankle? [ ] Yes [ ] No If YES, Please explain: \_\_\_\_\_

Shoe Size: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**PAST AND PRESENT MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLIES TO YOU)**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Childhood Diseases                       | <input type="checkbox"/> Osteo (aging) Arthritis | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> HIV / AIDS        |
| <input type="checkbox"/> Stomach Problems (Ulcers, Colitis)       | <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Gout              |
| <input type="checkbox"/> <b>DIABETES</b> (Insulin or non-insulin) | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Asthma/Emphysema     | <input type="checkbox"/> Heart Condition   |
| <input type="checkbox"/> Rheumatic Fever                          | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Liver Diseases    |
| <input type="checkbox"/> Epilepsy or Seizure                      | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Blood Disorders      | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> On Coumadin/ Blood thinners              | <input type="checkbox"/> Mitral Valve Prolapse/  | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Lyme Disease      |
| <input type="checkbox"/> Slow Wound Healing                       | <input type="checkbox"/> Hear Murmur             | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Back Pain         |
| <input type="checkbox"/> Numbness of Feet                         | <input type="checkbox"/> Ankle/ Feet Swelling    | <input type="checkbox"/> Frequent Infections  | <input type="checkbox"/> Bleeding Problems |

Do you Smoke? [ ] Yes [ ] No If YES, # of packs/day: \_\_\_\_\_ Previously Smoked? [ ] Yes [ ] No If YES, # packs/day: \_\_\_\_\_

Do you drink Alcohol? [ ] Yes [ ] No If YES, how much? [ ] 1-2 drinks/day [ ] more than 2 drinks/day [ ] 1-2 drinks/week

Have you had Previous Surgery? [ ] Yes [ ] No What Type and Year? \_\_\_\_\_

**DO YOU HAVE TO BE PRE-MEDICATED WITH ANTIBIOTICS BEFORE HAVING DENTAL WORK DONE? YES / NO**

**ALLERGIES (CHECK THOSE THAT APPLY)**

- |  |                                     |                                    |   |  |
|--|-------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> No Known Allergies                  | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Aspirin          | <input type="checkbox"/> Dental Anesthesia |
| <input type="checkbox"/> Latex                               | <input type="checkbox"/> Band-aids  | <input type="checkbox"/> Tape      | <input type="checkbox"/> Iodine (Seafood) |  |
| <input type="checkbox"/> Other Allergies, Please list: _____ |                                     |                                    |   |  |

**PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING INCLUDING OTC's AND WHAT ARE THEY USE FOR:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employment Conditions: [ ] Sits at Job [ ] Stands at Job [ ] Stands/Walks at Job [ ] Retired

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**