"We keep you walking, We keep you healthy"

PODIATRY SERVICES OF ITHACA

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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)

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

OTHERS: _____

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 ALL THOSE THAT APPLY)

___ No Known Allergies	___ Penicillin	___ Cortisone	___ Aspirin	___ Dental Anesthesia
___ Latex	___ Bandaids	___ Tape	___ Iodine (Seafood)	

___ 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**