Advanced Foot and Ankle Clinic

PERSONAL & MEDICAL INFORMATION DATE: _____

Patient Name: _____ Date of Birth: _____ _____ _____
(last) (first) (middle)

PATIENT MEDICAL HISTORY/STATUS

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Circle either "YES" or "NO" to indicate if you have had, or are currently being treated for any of the following.

AIDS/HIV	YES	NO	DIABETES	YES	NO	HEART ATTACK	YES	NO
ANEMIA	YES	NO	If yes, since what year?	_____		HEPATITIS/JAUNDICE	YES	NO
ANGINA	YES	NO	DEPRESSION	YES	NO	KIDNEY DISEASE	YES	NO
ARTHRITIS	YES	NO	EPILEPSY	YES	NO	LIVER DISEASE	YES	NO
ASTHMA	YES	NO	FAINTING	YES	NO	LOW BLOOD PRESSURE	YES	NO
BACK PROBLEM	YES	NO	GOUT	YES	NO	LUNG DISEASE	YES	NO
BLEEDING DISORDER	YES	NO	GLAUCOMA	YES	NO	PHLEBITIS	YES	NO
CANCER	YES	NO	HEADACHES	YES	NO	RHEUMATIC FEVER	YES	NO
CHEMICAL DEPENDENCY	YES	NO	HEART DISEASE	YES	NO	STROKE	YES	NO
CIRCULATION	YES	NO	HIGH BLOOD PRESSURE	YES	NO	STOMACH ULCERS	YES	NO

OTHER HEALTH HISTORY: _____

HOSPTIAL VISITS: _____

SURGERIES: _____ When: _____

MEDICAL DOCTOR: _____

Other Doctors: _____

Pharmacy: _____

WEIGHT: _____ HEIGHT: _____

MEDICATIONS: (supply list if possible)

Medication Name	Dosage

List other medication on reverse side, if needed

ALLERGIES: If yes, what happens:

Adhesive tape	YES	NO	
Aspirin/Empirin	YES	NO	
Codeine/Morphine	YES	NO	
Novocain	YES	NO	
Iodine/shell fish	YES	NO	
Penicillin	YES	NO	

OTHER Allergies: _____

FAMILY HISTORY - List family member who has/had:

Diabetes _____
Arthritis _____
Stroke _____
Heart Attack _____
High Blood Pressure _____
Other _____

Do you SMOKE: YES NO How long? _____
Packs per day If quit, when _____
ALCOHOL: none / rarely / moderately / daily / quit
Recreational Drugs: none / rarely / moderately / daily / quit

LIST PRIMARY REASON FOR VISIT: _____

What type of EXERCISE ACTIVITIES do you participate in? _____

WHO REFERRED YOU? (circle one) Primary doctor / insurance book / family / friend / yellow pages / other: _____
If doctor/family/friend, please list name: _____

I certify that the above information is correct regarding myself, or my dependents. I give permission to Dr. Travis S. Carter and staff to perform such procedures or tests as may be deemed necessary in the diagnosis and/or treatment of myself, or my dependent's lower extremity concerns.

Signature: _____ Relationship, if signing for dependent _____