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: _____

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** _____