Capital City Foot & Ankle Center LLC

MEDICAL HISTORY

MEDICATIONS

Pharmacy Name _____

List the OTC & Prescription Drugs you take :

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

MEDICAL PROBLEMS

Arthritis/Rheumatism	___ NO ___ YES
Artificial Joints	___ NO ___ YES
Asthma	___ NO ___ YES
Cholesterol Disease	___ NO ___ YES
Heart Disease	___ NO ___ YES
High Blood pressure	___ NO ___ YES
Kidney Problems	___ NO ___ YES
Liver Disease	___ NO ___ YES
Psychiatric Diseases	___ NO ___ YES

ALLERGIES

__Adhesive/Tape
__ Anticoagulant Therapy
__ Aspirin
__ Codeine
__ Demerol
__ Iodine
__ Local Anesthetics
__ Novocain
__ Penicillin
__ Seafood
__ Sulfa
__ Other

PODIATRIC HISTORY

Current Foot & Ankle problem/problems:-

_____

_____

_____

Tobacco Use _____ Yes _____ No Years smoked _____

Alcohol use _____ Yes _____ No

Illicit Drug use _____ Yes _____ No

Surgeries you had _____

_____

Family Physician _____

Last Visit _____

Family Physician /Practice Group

_____

Ankle Pain---------- __ Yes __ No
Athletes Foot-------- __ Yes __ No
Bunions---------- __ Yes __ No
Corns and Calluses-- __ Yes __ No
Cramps/Numbness- __ Yes __ No
Flat Feet ---------- __ Yes __ No
Heel pain---------- __ Yes __ No
Ingrown Toenails---- __ Yes __ No
Planter Warts-------- __ Yes __ No
Swelling---------- __ Yes __ No
___ Tired Feet _____ __ Yes __ No

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to the Doctor to perform such procedures as may be deemed in the diagnosis and or treatment of my feet.

Date _____

Patient's Name _____ Signature _____