NAME:______________________________

INITIAL PATIENT HISTORY

Please indicate whether or not you have experienced any of the following.

PAST & PRESENT MEDICAL/SURGICAL HISTORY

	NO	YES	Comments
Anemia	❑	❑	
Arthritis	❑	❑	
Asthma	❑	❑	
Bladder Infection	❑	❑	
Bleeding Problems	❑	❑	
Blood Clot	❑	❑	
Blurred Vision	❑	❑	
Cancer	❑	❑	
Chest Pain	❑	❑	
Cigarette Smoking	❑	❑	
Cyst/Skin Growth	❑	❑	
Diabetes	❑	❑	
Depression	❑	❑	
Epilepsy(Seizures)	❑	❑	
German Measles(Rubella)	❑	❑	
Headaches	❑	❑	
Heart Disease	❑	❑	
Hemorrhoids	❑	❑	
Hernia	❑	❑	
High Blood Pressure	❑	❑	
High Cholesterol	❑	❑	

	NO	YES	Comments
Kidney Disease	❑	❑	
Liver Disease or Hepatitis	❑	❑	
Mononucleosis	❑	❑	
Pelvic or Menstrual Pain	❑	❑	
Rheumatic Fever	❑	❑	
Shortness of Breath	❑	❑	
Sickle Cell Anemia	❑	❑	
Skin Problems	❑	❑	
Stroke	❑	❑	
Stomach/Bowel Problems	❑	❑	
Swelling	❑	❑	
Thyroid Problems	❑	❑	
Tuberculosis	❑	❑	
Varicose Veins	❑	❑	
Venereal Disease	❑	❑	
Surgery	❑	❑	
Previous Foot Problems	❑	❑	
Other Illness	❑	❑	

ARE YOU ALLERGIC TO:

	NO	YES	Comments
Penicillin	❑	❑	
Tetracycline	❑	❑	
Aspirin	❑	❑	
Codeine	❑	❑	
Sulfa	❑	❑	

	NO	YES	Comments
Iodine	❑	❑	
Latex	❑	❑	
Any Kind of Food	❑	❑	
Any Metals (Jewelry)	❑	❑	
Other Allergies	❑	❑	

FAMILY HISTORY

Are you Adopted? NO ❑ YES ❑

Have your grandparents, parents, brothers or sisters ever had:

	NO	YES	Comments
Cancer	❑	❑	
Diabetes	❑	❑	
Heart Attack	❑	❑	
High Blood Pressure	❑	❑	

	NO	YES	Comments
Sickle Cell Disease	❑	❑	
Stroke or Blood Clots	❑	❑	
High Cholesterol	❑	❑	
Others	❑	❑	

DO YOU TAKE ANY MEDICATIONS? PLEASE LIST THEM:

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Are you pregnant? NO ❑ YES ❑ *Are you Breastfeeding?* NO ❑ YES ❑

EMERGENCY CONTACT:

Name: ______________________________ Telephone Number: ______________________________

Patient Signature:______________________________ Date: ______________________________

Reviewed by: ______________________________ Date: ______________________________

Rajeev Sehgal, DPM, FACFAS