The Foot and Ankle Wellness Center
of Western Pennsylvania

Medical History

Today's Date: ..../........../.......... Patient Number: ....

Patient Name: .... Sex: .... Age: ....

Describe Your Foot Problem: ....

....

Have you had any previous foot care or surgery? ☐ Yes ☐ No

If yes, by whom? .... How Long Ago: ....

Primary Care Physician: .... Date Last Seen: ..../........../..........

GENERAL HEALTH

Blood Pressure: ..../.......... Height: .... Weight: .... Lbs. Shoe Size: ....

(***Please check*** *any of the following which* ***you*** *and* ***your family*** *have been or are being treated.)*

Self	Family		Self	Family	
☐	☐	Asthma	☐	☐	Cardiac Disease
☐	☐	Arthritis (Type)	☐	☐	Glaucoma/Eye
☐	☐	Mitral Valve Prolapse (Heart Murmur)	☐	☐	Breathing Problems
☐	☐	Scarlet Fever	☐	☐	Venereal Disease
☐	☐	Hypertension (High blood Pressure)	☐	☐	Hemophilia (Bleeder)
☐	☐	Peripheral Vascular Disease (Circulation)	☐	☐	Stomach Problems (Ulcer)
☐	☐	Tuberculosis	☐	☐	Renal Disease (Kidney)
☐	☐	Gout	☐	☐	Polio, Cerebral Palsy, Muscular Dystrophy
☐	☐	Cerebral Accident (Stroke)	☐	☐	Phlebitis/Thrombophlebitis (Clot)
☐	☐	Diabetes	☐	☐	Anemia (Blood Disorder)
☐	☐	Liver Disease (Hepatitis)	☐	☐	Thyroid Disease (Hypo or Hyper)
☐	☐	Epilepsy (Convulsions)	☐	☐	Slow Healer
☐	☐	HIV Positive (Aids)	☐	☐	Previous Blood Transfusion (If yes, When?) ....
☐	☐	Other – Please state			

Woman Are you Pregnant? ☐ Yes ☐ No LMP: .... Due Date: ..../........../..........

ALLERGIES

Are you allergic to any of the below? ***Please check below:***

☐ Penicillin	☐ Tetracycline	☐ Aspirin	☐ Sulfa Drugs
☐ Novicaine	☐ Codeine	☐ Barbiturates	☐ Cortisone
☐ Iodine Dyes	☐ Foods	☐ Adhesive Tape	☐ Environmental
☐ Caffeine	☐ Other:		

The Foot and Ankle Wellness Center of Western Pennsylvania

Medical History

PERSONAL SOCIAL HISTORY

Tobacco: .... per Day: .... Years: ....
Alcohol: .... oz. per week: .... Caffeine: .... Cups per Day
Recreational Drugs: .... Name of Drug(s): ....
Occupation: ....
Activities: .... Exercise: ....

MEDICATIONS

Are you taking any medication(s)? ☐ Yes ☐ No If Yes Please List Below:
(Please include your prescription medication, Vitamins, Birth Control Pills, Herbs and any over the counter Medications)

.... 1. ....
.... 2. ....
.... 3. ....
.... 4. ....
.... 5. ....
.... 6. ....
.... 7. ....
.... 8. ....
.... 9. ....
.... 10. ....

SURGICAL OR HOSPITALIZATION HISTORY

Have you had any surgery intervention or hospitalization? ☐ Yes ☐ No
If yes please list: ....

....

CONSENT FOR TREATMENT

The above information is correct to the best of my knowledge and consent to such diagnosis procedures (including x-rays) and medical care and treatment as deemed necessary by The Foot and Ankle Wellness Center of Western Pennsylvania.

X: ____________________ Date: ..../..../....
Signature of Patient or Consenter

X: ____________________
Witness

CONSENT FOR PHOTOGRAPHY

I hereby authorize The Foot and Ankle Wellness Center of Western Pennsylvania to take medical photographs which are to be used solely for the purpose of education.

X: ____________________ Date: ..../..../....