PATIENT NAME: ____ DATE: ______________

WEIGHT: ___________ HEIGHT: __________ SHOE SIZE: __________ AGE: ___________

DESCRIBE ANY PROBLEMS YOU ARE HAVING WITH YOUR FEET AND/OR ANKLES:

____

____

PLEASE CHECK THE ONE THAT APPLIES:
( ) I HAVE NO ALLERGIES
( ) I AM ALLERGIC TO THE FOLLOWING:

( ) ASPIRIN	( ) DEMEROL	( ) LOCAL ANESTHETICS	( ) ____________________
( ) CODEINE	( ) SULFA	( ) PENICILLIN	( ) ____________________
( ) IODINE	( ) LATEX	( ) ____________________	( ) ____________________

IF YOU ARE UNDER THE CARE OF OTHER DOCTORS, PLEASE LIST THEIR NAMES:

____

MEDICAL PROBLEMS FOR WHICH YOU ARE BEING TREATED:

____

____

LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING PRESCRIPTION DRUGS, HERBAL REMEDIES, AND OVER THE COUNTER MEDICATIONS):

_______________ _______________ _______________ _______________ _______________

_______________ _______________ _______________ _______________ _______________

PREVIOUS SURGERIES (LIST PROCEDURE AND DATE):

____

HABITS/SOCIAL HISTORY:

TOBACCO: ______ PACKS/DAY ______ YEARS. PREVIOUS QUIT (Y / N)

ALCOHOL:
DRINKS PER DAY: ________ PER WEEK: ________ PER MONTH: _________
PLEASE SPECIFY: ____

RECREATIONAL DRUG USE (Y / N) PLEASE SPECIFY: ____________________________

____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?
PLEASE CHECK ANY THAT APPLY:

( ) ANEMIA	( ) HEPATITIS/LIVER DISEASE
( ) ARTHRITIS/RHEUMATISM	( ) HIGH BLOOD PRESSURE
( ) ASTHMA	( ) HIV INFECTION
( ) BLEEDING PROBLEMS	( ) KIDNEY PROBLEMS
( ) CANCER	( ) LEG CRAMPS
( ) DIABETES	( ) NEUROMUSCULAR PROBLEMS
( ) EPILEPSY	( ) STOMACH ULCERS
( ) GOUT	( ) STROKE
( ) HEART PROBLEMS	( ) ________________________________

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CONSENT FOR TREATMENT: I GIVE CONSENT FOR MYSELF/SON/DAUGHTER (OR ___________________________________) TO UNDERGO EXAMINATION, LAB-WORK, X-RAY AND TREATMENT BY WINDY HILL PODIATRY ASSOCIATES, P.C.

Signed__________________________________ Relationship to Patient _______________________