SOUTHERN VERMONT PODIATRY

Medical information

Patient Name: _____

Give a brief description for today's visit: ☐ Right foot ☐ Left foot ☐ Both feet

_____

MEDICATIONS: (please list all medications or provide a list) ☐ **I currently take no medications**

_____

_____

ALLERGIES: ☐ **No Known Allergies**

☐ Adhesive Tape	Reaction: _____	☐ Local Anesthetics	Reaction: _____
☐ Aspirin	Reaction: _____	☐ Penicillin	Reaction: _____
☐ Codeine	Reaction: _____	☐ Seafood/Shellfish	Reaction: _____
☐ Demerol	Reaction: _____	☐ Sulfa Drugs	Reaction: _____
☐ Erythromycin	Reaction: _____	☐ Iodine	Reaction: _____

Others: _____

Height: _____' ____"

Weight: _____ lbs

Shoe Size: _____

Social History: Do you drink alcohol? Yes/No Amount: _____

Do you currently smoke? Yes/No Amount: _____

Have you ever smoked? Yes/No Amount: _____

MEDICAL HISTORY: Do you have or have you ever been treated for (*check **all** that apply*)

☐ Diabetes	☐ Alzheimer's	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Cancer: Location _____	☐ Epilepsy	☐ Fibromyalgia
☐ Glaucoma	☐ Chronic Fatigue Syndrome	☐ Gout	☐ Headaches
☐ Hearing Disorder	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure
☐ Hepatitis	☐ Keloid/Thick Scar	☐ Kidney Disease	☐ Liver Disease
☐ Lung Disease	☐ Lyme's Disease	☐ Osteoporosis	☐ Phlebitis
☐ Poor Circulation	☐ Rheumatic Fever	☐ Sciatica	☐ Stomach Ulcer
☐ Stroke	☐ Thyroid Problem	☐ Tuberculosis	☐ Venous Disease

☐ **None of the Above**

Please list any disease or condition not described above: _____

Pneumonia vaccine: ☐ No ☐ Yes Date:_____ Influenza vaccine: ☐ No ☐ Yes Date:_____

PODIATRIC HISTORY: Are you or have you ever suffered from

☐ Ankle/Foot Swelling	☐ Burning in feet	☐ Scaling of skin	☐ Arch pain	☐ Athletes foot
☐ Blisters	☐ Calf pain	☐ Cold feet	☐ Slow healing	☐ Stiffness
☐ Discoloration	☐ Dry skin	☐ Heel pain	☐ Itchy skin	☐ Joint pain
☐ Numbness	☐ Ulcers	☐ Flat feet	☐ High arches	☐ **None of the above**

Please list any leg or foot injuries or surgeries: _____

FAMILY HISTORY: **M** = mother**; F** = father**; B =** Both mother and father**.**

Diabetes ___, High Blood Pressure ___, Stroke ___, Gout ___, Poor circulation ___, Cancer ___, Heart attack ___,

Flat Feet ___, Bunions ___, Hammertoes ___, ☐ **None of the above**, Other: _____

The above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____ / _____ / _____