

PATIENT HEALTH RECORD

NAME: _____ DATE: _____

What is your present foot problem(s)? _____

How long have you been bothered by the above? _____

What have you done for your foot problem? _____

Medical History (This confidential information helps us determine proper treatment and medication)

Physician's Name _____ Phone _____

Physician's Address _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Yes	No		Yes	No
AIDS/HIV infection	___	___	Hepatitis/Jaundice	___	___
Anemia	___	___	Herpes	___	___
Artificial heart valves	___	___	High low blood pressure	___	___
Artificial joints/implants	___	___	Hives or skin rashes	___	___
Asthma	___	___	Kidney disease	___	___
Back or neck problems	___	___	Liver disease	___	___
Bruise or bleed easily	___	___	Pacemaker	___	___
Bulimia or anorexia	___	___	Psychiatric treatment	___	___
Cancer/tumor	___	___	Rheumatic fever	___	___
Chemical dependency	___	___	Seizures	___	___
Chest pain	___	___	Scarlet fever	___	___
Cortisone treatment	___	___	Shortness of breath	___	___
Diabetes	___	___	Sickle cell anemia	___	___
Epilepsy or neurological problems	___	___	Stomach ulcers	___	___
Fainting or dizzy spells	___	___	Stroke	___	___
Glaucoma	___	___	Phlebitis	___	___
Heart disease	___	___	Thyroid disease	___	___
Mitral valve prolapse	___	___	Tuberculosis	___	___
Heart murmur	___	___	Ulcers	___	___
Gout	___	___			

Do you have any disease, condition, or problem not previously listed? _____

Are you allergic to Penicillin ___ Codeine ___ Local anesthetics ___ Latex ___ Other _____

Are you under the care of a physician and why? _____

Have you been treated in a hospital in the past 2 years? _____

Please list all prescription drugs you are now taking (please include any herbal or over-the-counter medication) _____

Do you take vitamins regularly? If so, please list _____

Has your physician advised you to premedicate before dental treatment? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing _____

Have you ever had a blood test for hepatitis? _____ Have you been vaccinated? _____

Do you use tobacco? _____ Have you had a recent weight loss/gain? _____ Do you use alcohol? _____

Have you had surgery? _____ If so, what type? _____ Year _____

FAMILY HISTORY

Circle if any blood relatives have had:

Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Overweight

I HEREBY GIVE PERMISSION TO THE DOCTORS TO EXAMINE, DIAGNOSE AND TREAT MY FEET MEDICALLY, OR SURGICALLY AND ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Patient (parent/guardian) Signat _____