

**KENT FOOT AND ANKLE CENTER
WELCOME TO OUR PRACTICE**

Reason for your visit today? _____

Referred by whom? _____

Have you ever seen a podiatrist before? Yes No

If yes, whom? _____

Are your symptoms worse when wearing shoes? Yes No

Do you spend more than 50% of your day standing? Yes No

Has anyone in your family ever had a similar problem? Yes No

Are your symptoms worse when standing/walking? Yes No

Does your current condition affect your work/recreational activities? Yes No

YOUR MEDICAL HISTORY: Circle Yes or No

Rheumatic Fever	YES	NO	Stomach Ulcer	YES	NO	High Cholesterol	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Back Trouble	YES	NO	Bleeding Disorder	YES	NO	Hepatitis	YES	NO
Arthritis	YES	NO	High Blood Pressure	YES	NO	Circulatory Problems	YES	NO	Glaucoma	YES	NO
Anemia	YES	NO	Asthma	YES	NO	Gout	YES	NO	Liver Disease	YES	NO
Epilepsy	YES	NO	AIDS/HIV	YES	NO	Depression/Anxiety	YES	NO	Kidney Disease	YES	NO
Tuberculosis	YES	NO	Heart Attack	YES	NO	Emphysema	YES	NO	Thyroid Disease	YES	NO
Diabetes	YES	NO	Stroke	YES	NO	Skin Conditions	YES	NO			

Other: _____

Medication	Reason	Medication	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

NONE PENICILLIN CODEINE TAPE/ADHESIVES NOVOCAINE ASPIRIN FOODS SULFA DRUGS

Other: _____

PREVIOUS SURGERIES/HOSPITALIZATIONS:

WHAT YEAR?

SOCIAL HISTORY:

Marital Status: Married Single Separated/Divorced Widowed

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Previously but quit Currently-packs per day _____ Years _____

FAMILY HISTORY: AGE DISEASE IF DECEASED, CAUSE OF DEATH

FATHER _____
 MOTHER _____
 SIBLINGS _____

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on this form, I should ask the Doctor or a member of the office staff for assistance.

SIGNATURE: _____ DATE: _____