KENT FOOT AND ANKLE CENTER

WELCOME TO THE PRACTICE

Reason for your visit today _____

How did you hear about us? _____

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	Polio	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	Acid Reflux	YES	NO

Other Medical Conditions _____

Medication	**Dosage**	**Reason**	**Medication**	**Dosage**	**Reason**
1			**6**		
2			**7**		
3			**8**		
4			**9**		
5			**10**		

ALLERGIES:

NONE PENICILLIN CODEINE TAPE/ADHESIVES NOVOCAIN ASPIRIN SULFA DRUGS FOODS

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 states 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 foe assistance.

X_____ Date _____

Signature of Patient or Parent, if Minor