

Saddleback Valley Podiatry Group
Medical History

Do you have or have you ever had?

	YES	NO		YES	NO
Diabetes	_____	_____	Lung Disease	_____	_____
Heart Disease	_____	_____	Blood Condition	_____	_____
Kidney Disease	_____	_____	Vascular Disease	_____	_____
High Blood Pressure	_____	_____	Phlebitis	_____	_____
Problems Healing	_____	_____	Asthma	_____	_____
Any condition requiring pre-medication with antibiotics				_____	_____

Do you take any of the following medications?

	YES	NO	Medication
Insulin	_____	_____	_____
Oral diabetic medication	_____	_____	_____
Blood thinner	_____	_____	_____
Water pills	_____	_____	_____
Heart Medication	_____	_____	_____
Birth control pills	_____	_____	_____
Thyroid supplements	_____	_____	_____
Estrogen	_____	_____	_____
Other medications: _____			

Are you allergic or sensitive to any medication or substance?

	YES	NO		YES	NO
Local anesthetics	_____	_____	Adhesive or tape	_____	_____
Cortisone	_____	_____	Penicillin	_____	_____
Sulfa	_____	_____	Codeine	_____	_____
Iodine	_____	_____	Other: _____		

If female are your pregnant? Yes _____ No _____

Past hospitalizations: _____

Previous surgeries: _____

Serious illnesses and injuries: _____

Have you been treated for this condition before? _____

Have you ever had foot surgery? _____

Have you ever had foot x-rays? _____

Do you smoke? Yes _____ No _____ How much? _____

Do you drink alcohol? Yes _____ No _____ How much? _____

Date: _____

Patient or Parent Signature