Suppan Foot & Ankle Clinic

PATIENT MEDICAL HISTORY

Name: _____ Today's Date: _____

Height: _____ Weight: _____ Birthdate: _____

Have you ever had any of the following?

___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Cancer
___ Blood Clot in Calf of leg
___ Depression
___ Diabetes
___ Epilepsy
___ Excessive bleeding
___ Gout
___ Heart disease
___ History of stroke in the past year
___ HIV
___ High blood pressure
___ High cholesterol
___ Joint replacement
___ Kidney disease
___ Liver disease
___ Mental disorder
___ Mitral valve prolapse
___ Osteoporosis
___ Pacemaker
___ Paralysis
___ Poor circulation
___ Spine disorder
___ Stroke
___ Thyroid disease
___ Any other disease
_____
_____
_____

Drug Allergies: _____

Food/Environmental Allergies: _____

Medications *(please complete all sections)* :

Medication Name	***Strength (mg, mcg, etc.)***	***How Many***	***How Often: (Times/Day, etc.)***	***Form (tablet, capsule, etc.)***	***Route (Oral, skin, etc.***

Preferred Pharmacy: _____

Social History:

Tobacco Current: Y N Former: Y N Cigarettes: Packs per day: _____ for _____ years
Cigar: _____ Chewing Tobacco: _____

Alcohol Y N Drinks per week: _____
Caffeine Y N Cups per day: _____
Illegal Drugs Y N Type: _____

Are you pregnant? _____

Any problems with Anesthesia, Injections, etc.? _____

Previous Surgeries:

Year:	Operation: