Suppan Foot & Ankle Clinic

PATIENT MEDICAL HISTORY

Name: ______________________ Birthdate: ______________________ Today's Date: ______________

Have you ever had any of the following?
Check all that apply

_____ 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
_____ Spine disorder
_____ Stroke
_____ Thyroid disease
_____ **Other disease (s)**
____
____

Has a member of your immediate family (mother, father, sister, brother, son, daughter) **had any of the following?**

_____ Anesthesia Reaction ______________________
_____ Arthritis ______________________
_____ Blood Disorder ______________________
_____ Cancer ______________________
Type: ______________________
_____ Diabetes ______________________
_____ Excessive Bleeding ______________________
_____ Heart disease ______________________

Drug Allergies: ______________________

Flu Immunization (Month, Year) ______________________

Last PCP Visit: ______________________

Pharmacy: ______________________

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.)

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.? ______________________

Height: ______________ Weight: ______________ Any falls in the last 6 months? ______________________

Previous surgeries:

Year:	Operation: