Patient Health Information Form ~ This information is confidential

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Date:_____

Patient's Name: _____
Last/apellido *first/nombre* *middle*

Birth Date:_____ Age:_____ Male ___ Female___ Height/Estatura:_____ Weight/Peso:_____

Family Doctor:_____ Phone #: ( ) _____
Doctor familiar

Doctor's Address:_____
Direction Street City State/Zip code

Previous Podiatrist? Name:_____ Date of last visit:_____
Podiatra anterior

Briefly describe your foot / ankle problem:_____
Cual es el problema de su pie(s)
_____. How long? _____
Por cuanto tiempo

Have you ever had foot surgery? ___yes ___no If yes, when? _____ _____
Cirulia de los pies
For what condition?_____

If female, are you pregnant? ____yes ____no

Are you in good health? ___yes ___no Do cuts and wounds heal slowly? ___yes ___no
Se considera en buena salud *Las heridas y cortadas se le curan lentamente?*

Medical History: Please check if any of the following problems exist or have occurred in the past:
Historia Medica: Solo marque las que califican con su historial

__Diabetes	__Varicose Veins	__Hepatitis	__Leg Cramps
__Stomach trouble	__Numbness in feet or legs	__High blood pressure	__Ulcers
__Heart trouble	__ Palpitations	__Stroke	__Bleeding problems
__Phlebitis	__Rheumatic Fever	__Heart Murmur	__Tuberculosis
__Kidney Disease	__Liver Disease	__Broken bones	__Gout
__Cancer	__Low back pain	__infections	__AIDS or HIV

__surgeries / other_____

What medications are you taking?_____,_____,_____,_____,_____,_____
Esta tomando algun medicamento

Allergies: ___none ___Penicillin ___Sulfa ___Local Anesthetics ___Iodine ___Codeine
Alergias ___Adhesive tapes ___other _____

Social History: Do you smoke? _____ If so, how much? And how long?_____

Occupation _____

How many hours are you on your feet each day?_____

What sports do you participate in?_____
Family History:
___Diabetes ___High Blood pressure ___Heart Disease ___Stroke ___Foot or leg problems

Any other medical conditions we should know about?_____