MEDICAL HISTORY

Please circle "**Current**" or "**Past**" if you have had any of the following.

AIDS/HIV	Current	Past
Anemia	Current	Past
Bleeding Disorder	Current	Past
Cancer	Current	Past
Hemophilia	Current	Past
Swollen Neck Glands	Current	Past
Angina	Current	Past
Artificial Heart Valve	Current	Past
Chest Pain	Current	Past
Circulatory Problem	Current	Past
Heart Disease	Current	Past
High Blood Pressure	Current	Past
Low Blood Pressure	Current	Past
Rheumatic Fever	Current	Past
Stroke	Current	Past
Swelling Ankles/Feet	Current	Past
Heart Attack	Current	Past
Rheumatoid Arthritis	Current	Past
Arthritis	Current	Past
Back Problems	Current	Past
Gout	Current	Past
Asthma	Current	Past
Emphysema	Current	Past
Respiratory Disease	Current	Past
Shortness of Breath	Current	Past
Tuberculosis	Current	Past
Chemical Dependency	Current	Past
Psychiatric Care	Current	Past
Diabetes	Current	Past
Thyroid Disease	Current	Past
Eye Problems	Current	Past
Sinus Problems	Current	Past
Headaches	Current	Past
Phlebitis	Current	Past
Varicose Veins	Current	Past
Claudication (Leg cramps from walking)	Current	Past
Hepatitis	Current	Past
Jaundice	Current	Past
Liver Disease	Current	Past
Heart Burn	Current	Past
Ulcers	Current	Past
Weight Loss-unexplained	Current	Past
Numbness or tingling (in feet or legs)	Current	Past
Seizures	Current	Past
Fainting	Current	Past
Neurological Problems	Current	Past
Venereal Disease	Current	Past
Kidney Problems	Current	Past
Rash	Current	Past

ALLERGIES

___ Adhesive Tape
___ Anticoagulant Therapy
___ Aspirin
___ Codeine
___ Cortisone
___ Demerol
___ Iodine
___ Local Anesthesia
___ Novocaine
___ Penicillin
___ Seafood
___ Sulfa
___ Other _____

SURGERIES

Surgeries I have had _____
_____
_____
_____
_____
_____
_____
_____
_____

Family history of Diabetes Yes___ No____
Cancer…Yes____No____(whom)_____

PODIATRIC HISTORY

Describe the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.

_____

_____

_____

_____

_____

_____

How long?
___ Weeks ___ Months ___ Years

On a scale of 1-10 how bad is pain?
1 2 3 4 5 6 7 8 9 10
Minimal Severe

Cigarette/Tobacco use? Current Past
Years smoked? _____

How much alcohol do you consume?
___Daily ___ Weekly ___ Monthly

Have you had a flu or pneumonia vaccine?
Yes:____ No:____ Date:_____

FOOT DISORDERS

Please indicate which foot problems you Past have or had in the past.

Ankle Pain	Current	Past
Athlete's Foot	Current	Past
Bunions	Current	Past
Corns & Calluses	Current	Past
Deformed Toes	Current	Past
Fungus Nails	Current	Past
Heel Pain	Current	Past
Ingrown Toenails	Current	Past
Plantar Warts	Current	Past
Infection	Current	Past
Ulcer/Wound	Current	Past
Tired Feet	Current	Past

MEDICATIONS

Include prescriptions, over the counter medications and vitamins.

_____
_____
_____
_____

___ Listed additional meds on back.
Pharmacy Name _____
Pharmacy Phone _____

CONSENT

I certify that the above information is correct to the best of my knowledge. I give permission to Dr. Menendez to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature _____ Date _____