CAFENGIU PODIATRY & SPORTS MEDICINE

Medical History - Confidential Information

Patient Name:____

Today's Date:____/____/____ **Patient's Date of Birth:**____/____/___

Lower Extremity Medical History

What is the chief reason for your visit?
(Include foot, ankle, leg, knee and hip complaints)

____
____
____
____
____

Any previous foot / ankle / leg injuries or problems?

____
____
____

Have you been previously treated by a podiatrist?
- yes • no

Name of podiatric physician:__________________
Date last seen:____/____/____

General

Height:______ Weight:_______ Shoe Size:_____

Social History

Do you smoke? • yes • no
How Much? ____ packs / ________
Years Smoked:_________
Drink Alcohol? • yes • no
How Much:___________
Recreational Drugs? • yes • no
What type:____________
Pregnant or possibly pregnant? • yes • no
Athletic activities in which you participate:

____

Diabetics Only

- Oral Med • Insulin Dependent (check one)

Insulin dosage:__________________________

Years diagnosed with Diabetes:_______________

Physician treating Diabetes?__________________

Date of most recent visit:____/____/____

Runners Only

How long have you been running?_____________
Previous running injuries? • yes • no
Mileage:_______miles per • wk • month
Current running shoes:_______________________
Currently training? • yes • no

Medications

List all medications you are taking;
(including any over-the-counter medications or herbal remedies:)

____
____
____
____
____
____
____
____
____

Surgeries, Illnesses, Injuries

List surgeries, serious injuries and illnesses
not previously listed:_________________

____
____
____
____

Family History

List any significant family medical history:

____
____
____
____

Allergies and Drug Intolerance

- None / Unknown
- Aspirin
- Penicillin
- Codeine
- Sulfa
- Demerol
- Local Anesthetics
- Iodine / Shellfish
- Adhesive / Tape
- ______________

Mental / Emotional

- yes • no Eating Disorder
- yes • no Anxiety
- yes • no Depression
- yes • no Psychiatric
- yes • no Alcoholism

General Medical History

Mark "yes" or "no" to indicate if you have any of the following:

- yes • no Anemia
- yes • no Arthritis: Type:__________
- yes • no Artificial Heart Valve or Joints
- yes • no Asthma
- yes • no Back Problems
- yes • no Bleeding disorder
- yes • no On Coumadin (Anti-coagulant)
- yes • no Cancer
- yes • no Chemical Dependency
- yes • no Chest Pain
- yes • no Circulatory Problems
- yes • no Diabetes
- yes • no Epilepsy
- yes • no Fibromyalgia
- yes • no Gout
- yes • no Heart Disease
- yes • no Hemophilia
- yes • no Hepatitis
- yes • no High Blood Pressure
- yes • no HIV Positive
- yes • no Kidney Problems
- yes • no Leg Cramps
- yes • no Liver Disease
- yes • no Lung/Respiratory
- yes • no Mental Illness
- yes • no Phlebitis / Clots
- yes • no Psoraisis
- yes • no RSD
- yes • no Stroke
- yes • no Thyroid Problems
- yes • no Tuberculosis
- yes • no Ulcers—Stomach
- yes • no Venereal Disease
- yes • no Weight Change Recent_____lbs

Other:_____________________