Ankle & Foot Specialists

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Medical History Questionnaire

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Phone #: _____

	Yes	No
Are you allergic to any medications?		
Are you allergic to any anesthetic drugs?		
Do you drink alcohol?		
Do you smoke?		
Are you or could you be pregnant?		

Are you taking or have you recently been taking medications for:

	Yes	No
Blood Pressure		
Other heart medication		
Diuretics (water pills)		
Anti Depressants		
Tranquilizers or Sedatives		
Blood Thinners		
Steroids		
Insulin		
Other diabetic medication		
Anti-seizure medication		
Eye drops		

Please List Current Medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Patient or Responsible Party

_____

Patient's Name (print)

_____

Date

Have you recently had or do you still have….	Yes	No
A cold?		
Bronchitis?		
A cough?		
Frequent sinus problems?		
Emphysema?		
Asthma?		
Pneumonia?		
Shortness of Breath?		
Tuberculosis?		
Any other lung trouble?		
High or Low Blood Pressure? (circle)		
Heart Failure?		
Heart Murmur?		
Chest Pain, angina?		
Heart attack(s)?		
Palpations, irregular or fast heart beat?		
Rheumatic fever?		
Anemia?		
Sickle cell illness?		
Easy bruising, excessive bleeding?		
Jaundice, Hepatitis, liver trouble?		
Back Pain or injury?		
Slipped disk, sciatica?		
Arthritis or other joint pain?		
Convulsions, epilepsy?		
Fainting, black out spells?		
Stroke?		
Polio, paralysis, meningitis?		
Thyroid trouble?		
Diabetes?		
Low Blood Sugar?		
Kidney trouble?		
Heart burn?		
Ulcer?		
Hernia?		
Any other illness not mentioned above?		