TIDEWATER
Foot & Ankle Associates

PATIENT HISTORY

Name: _____ DOB: _____ Shoe Size: _____

Reason for your visit: _____

Primary Physician: _____ Doctor's Phone #: _____ Last Visit:_____

MEDICATIONS

Name of medication	Dosage	How often?	Condition being treated

ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

☐ Penicillin ☐ Anesthetics ☐ Iodine/Shrimp ☐ Aspirin ☐ Sulfa ☐ Latex ☐ Codeine ☐ Demerol

☐ Darvocet ☐ Cortisone ☐ Other: _____

MEDICAL HISTORY *Please check any of the following that you have now or have had in the past

☐ Diabetes*	☐ Fibromyalgia	☐ Asthma/ COPD	☐ Skin Disorders	☐ Nerve conditions	☐ Heart Problems
☐ Arthritis	☐ Gout	☐ Tumors	☐ Glaucoma	☐ Stomach Ulcers	☐ TB
☐ Anemia	☐ Bursitis	☐ AIDS (HIV)	☐ Lung Disease	☐ Kidney Problems	☐ Sickle Cell
☐ Osteoporosis	☐ Hepatitis	☐ Stroke	☐ Colitis/ Crohn's	☐ Bleeding Problems	☐ Epilepsy
☐ Mental Disorders	☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Reflux/ Heartburn	☐ High Cholesterol
☐ Thyroid Disease	☐ Joint Implants	☐ Poor Circulation	☐ STD	☐ Rheumatic Fever	☐ Cancer: (Type)
☐ Other:					

Past Surgeries: (please list): _____

_____

Do you have any of the following?

Pacemaker ☐ Yes ☐ No Date of last Physical: _____

Joint Implants ☐ Yes ☐ No Date of last Flu Shot: _____

Artificial Heart Valve ☐ Yes ☐ No Date of last pneumococcal Vaccine: _____

***Hx of Diabetes** ☐ Insulin ☐ Non- Insulin

Date of last A1C: _____Result: _____%

Date of last DM Eye Exam: _____

Eye Doctor Name: _____

SOCIAL HISTORY

Do you use Tobacco (Pipe, chew, cigars, cigarettes, etc.)? ☐ Yes ☐ No

Smoking Status: ☐ Current ☐ Former ☐ Never

I certify that the above is correct to the best of my knowledge and authorize Tidewater Foot & Ankle Associates to obtain my medical records from the above-mentioned physicians

Signature: _____ Date: _____