Las Cruces Family Foot & Ankle

Medical History

Allergies and Reactions _____

_____

Do you have **diabetes**? YES NO If yes, are you on insulin? YES NO

Have you had any of the following?

Acid Reflux	Y	N	Hepatitis	Y	N	Skin Ulcer	Y	N
Anemia	Y	N	High Blood Pressure	Y	N	Sleep Apnea	Y	N
Arthritis	Y	N	HIV+/AIDS	Y	N	Stomach Ulcers	Y	N
Artificial Joints	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Artificial Heart Valve	Y	N	Liver Disease	Y	N	Swelling Foot/Ankle	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N	Taken Blood Thinners	Y	N
Blood Clots	Y	N	Psoriasis	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Neuropathy	Y	N	Poor Circulation	Y	N
Gout	Y	N	Open Sores	Y	N	Depression	Y	N
Fibromyalgia	Y	N	Sickle Cell Disease	Y	N	High Cholesterol	Y	N
Heart Attack	Y	N	Seizures	Y	N	Other Conditions:	Y	N
Heart Disease/Failure	Y	N	Skin Disorder	Y	N		Y	N

Recent Hospitalization

_____

Are you currently in Pain Management? Yes No if yes, name of Doctor_____

Current Medications, Dosage, and Instructions (Include Prescriptions, Over-the-Counter Meds and Herbal Supplements.)

_____

_____

Previous Surgeries (Type and Date)

_____

_____

CONSENT FOR TREATMENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Print Name of Patient, Parent or Guardian **Date**

_____

Signature