PRE-SURGICAL MEDICAL HISTORY

Patient's Name_______________________________________________________________________________________

Health at Present_____________________________________________________________________________________

If you have a history of any of the following conditions, please check the appropriate box(es):

☐ Anemia                          ☐ Circulation                          ☐ Heart Disease                          ☐ Scarlet Fever
☐ Arthritis                          ☐ Diabetes                          ☐ Hepatitis                          ☐ Septic Ulcers
☐ Bleeding Disorders                          ☐ Glaucoma                          ☐ Hypertension                          ☐ Stroke
☐ Cancer                          ☐ Gout                          ☐ Polio                          ☐ Tuberculosis

Other______________________________                                      Last Medical Exam________________________

Medications_________________________________________________________________________________________

Allergies:   ☐ Aspirin                          ☐ Codeine                          ☐ Iodine                          ☐ PCN                          ☐ Tape
Other_____________________________________________________________________________________________

Have you had any serious illnesses?____If so, which?________________________________________________________

Have you had any previous surgeries?___If so, which?_______________________________________________________

Have you had any injury to your feet or legs?_____If so, explain._______________________________________________

Do you smoke?____________Do you drink alcohol?_______________Do you drink coffee?________________________

Any chance of pregnancy?____________Do you take birth control pills?_______________________________________

Review of Systems:

Head, Ears, Eyes, Nose, Throat ☐ Yes ☐ No                                      Heart or Lungs ☐ Yes ☐ No
Bladder or Urinary ☐ Yes ☐ No                                      Liver of Kidney ☐ Yes ☐ No
Stomach or Intestines ☐ Yes ☐ No                                      Musculosekeletal ☐ Yes ☐ No

Nature of Complaint___________________________________________________________________________________

Onset__________________________________________________________

Location________________________________________________________

Duration________________________________________________________

Self Treatments__________________________________________________