

Michigan Foot & Ankle Institute

Patient Name _____

Patient's Family Doctor: _____ Phone: _____

Patient's Pharmacy: Name _____ Location _____

Phone Number _____ Mail Order Pharmacy: _____

Please list any drug allergies: _____

Are you allergic to any of the following: Iodine Latex Shellfish Stainless steel Talc Tape

Please list medications you take regularly: _____

Height: _____ Weight: _____ Are you pregnant? Yes No

Do you smoke? _____ If yes, how many packs per day? _____ for # _____ years If no, when did you quit? _____

Do you drink alcohol? _____ How much? _____

List any past surgical history: _____

If you have had or have any of the following, please circle:

AIDS/HIV	Edema	Myocardial infarction (heart trouble)
Alzheimer's Disease	Glaucoma	Nephrotic syndrome (kidney problem)
Anxiety	Gout	Phlebitis
Anemia	Hepatitis	Polio
Arteriosclerosis	Hypercholesterolemia (high cholesterol)	PVD
Arthritis	Hypertension (high blood pressure)	Rheumatic Fever
Asthma	Hyperthyroid	Seizers
Atherosclerosis (circulation)	Hypotension (low blood pressure)	Stroke
Bleeding disorder	Hypothyroid	Tuberculosis (TB)
Cancer	Leg cramps	Ulcers
Cirrhosis of liver	Low back pain	Varicose veins
Depression	MRSA	

Do you have diabetes? _____ Type I _____ Type II _____ Insulin Dependent? _____

Please list family members who have diabetes (example: mother/father): _____

Any other medical history _____

My Foot/Ankle problem is: _____

How long have you had this problem? _____

Did this incident happen at work or a result of an auto accident? _____

Patient or Legal Guardian Signature _____ Date _____