Arizona Foot Specialists, LTD.

Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Aids/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Allergies to Anesthetics	☐ Yes ☐ No	Eyes Problems	☐ Yes ☐ No	Respiratory Issues	☐ Yes ☐ No
Allergies to Medicine or Drugs	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Foot Cramps	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Heart Valves or joints	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chest Pain	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No		
Chronic Diarrhea	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Ear Problems	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Surgeries you have had: _____

Hospitalizations other than for the surgeries listed: _____

_____

_____

Last visit date to Primary physician: _____

Are you now, or have you been, under any other's doctor's care for any reason over the past 2 years? ☐ Yes ☐ No

If yes, please explain: _____

_____

Medications

Include prescriptions, over-the-counter medications, contraceptives, and vitamins:

_____

_____

_____

Pharmacy Name(s) and Locations: _____

Pharmacy Phone Numbers: _____

Do you drink alcohol? Amount and frequency? _____

Allergies

☐ Adhesive/Tapes	☐ Local Anesthetics
☐ Anticoagulants	☐ Penicillin
☐ Aspirin	☐ Seafood
☐ Codeine	☐ Sulfa
☐ Demerol	☐ Iodine

☐ Other: _____

_____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Power of Attorney — Date

_____ _____

Please print name of patient — Date