

Albemarle-Charlottesville Podiatry Associates, Ltd

MEDICAL HISTORY (PLEASE COMPLETE)

Name: _____

Date: _____

Medical Information		Please Print	
Primary Care Physician	Date Last Seen	Former Podiatric Physician	Date Last Seen
Whom may we thank for referring you to this office?			
Reason for this exam or present problems with your feet:			
How long have you had these problems?			
Did the problem begin suddenly or gradually?			
Is this problem accident related? Y / N		Date/Time of accident	
If yes, how did you injure yourself?			

Allergies
List any and all drug or food allergies

Medical History					
Do you have any of the following conditions? (Please check Y/N)					
	Yes	No		Yes	No
Arthritis	<input type="radio"/>	<input type="radio"/>	Migraine	<input type="radio"/>	<input type="radio"/>
Asthma or emphysema	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Cancer or tumors	<input type="radio"/>	<input type="radio"/>	Poor circulation	<input type="radio"/>	<input type="radio"/>
Cellulitis	<input type="radio"/>	<input type="radio"/>	Polio	<input type="radio"/>	<input type="radio"/>
Chicken pox or shingles	<input type="radio"/>	<input type="radio"/>	Rheumatic fever	<input type="radio"/>	<input type="radio"/>
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	Seizure	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Slow healing sores	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	Stomach ulcers or gastritis	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
HIV or AIDS	<input type="radio"/>	<input type="radio"/>	Thyroid disorder	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Irregular heart beat	<input type="radio"/>	<input type="radio"/>	Venereal disease	<input type="radio"/>	<input type="radio"/>
Kidney problems	<input type="radio"/>	<input type="radio"/>	Other (please specify)	<input type="radio"/>	<input type="radio"/>

Surgical History
Please list all prior operations (with dates):

OFFICE USE ONLY	REVIEWED _____	DATE _____
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