

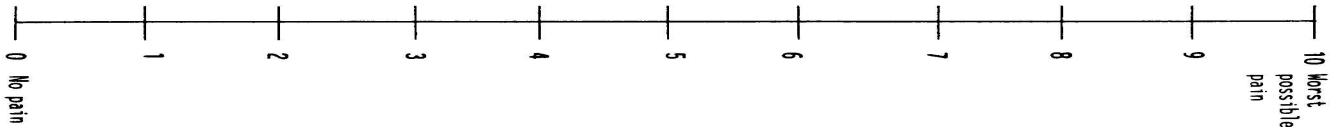


# New Patient Medical History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Initial

**What is/are the main reason(s) for your visit to us today?**  
 \_\_\_\_\_  
 \_\_\_\_\_

**If any pain on scale what is your pain level?**



**General Health:**

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

**Medical History P = Person History F = Family History**

P F Anemia's P F Arrhythmias P F Arthritis What type _____ P F Asthma P F Cancer What Type _____ P F Cerebral Palsy / Polio / MS / MD P F Cholesterol P F Diabetes How Many Years _____ P F Emphysema P F Glaucoma P F Gout	P F Heart Disease P F Hepatitis/Liver Disease P F High Blood Pressure P F HIV / Aids P F Kidney/Renal Disease P F PVD / poor circulation P F Rheumatic Fever P F Scarlet Fever P F Sexually Tr. Dis.(STD's) P F Sickle Cell Trait/Disease P F Strokes/TIA's	P F Thyroid _hyper _hypo P F Tuberculosis P F Ulcers Stomach / Duodenal / GERD P F Other – Please specify _____ _____ P F Other – Please specify _____ _____
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**Medications:** Please list all medications you are currently taking including: aspirin, over the counter medications and vitamins

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies** (check all that apply) **Reaction** (write the reaction to the medication for example – rash, hives, itching, difficulty breathing etc.)

___ Adhesive Tape _____	___ Latex _____	___ Foods _____
___ Aspirin _____	___ Local Anesthetics _____	___ Other Medications _____
___ Caffeine _____	___ Penicillin _____	_____
___ Codeine _____	___ Sulfa Drugs _____	_____
___ Cortisone _____		
___ Iodine _____		

**Surgical or Hospitalizations:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Woman:** Are you pregnant: \_\_\_\_\_ Yes \_\_\_\_\_ No      If yes, your due date: \_\_\_\_\_

**Tobacco Use:**

Do you smoke now? \_\_\_ Yes \_\_\_ No      How Long have you been smoking? \_\_\_\_\_  
 How long does a pack of cigarette last you? \_\_\_\_\_ Have you ever smoked? \_\_\_ Yes \_\_\_ No  
 How many years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_      How long does a pack of cigarette last you? \_\_\_\_\_

**Alcohol Use:**

Do you drink alcohol? \_\_\_ Yes \_\_\_ No      Do you drink some form of alcohol every day? \_\_\_ Yes \_\_\_ No  
 How many drinks will you consume in an average wee? \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-8 \_\_\_\_\_ over 10

**Drug use:**

Do you use drugs? \_\_\_ Yes \_\_\_ No      Which ones? \_\_\_\_\_  
 Have you ever used drugs intravenously? \_\_\_ Yes \_\_\_ No

**CONSENT OR TREATMENT**

I certify that the information above is true and correct to the best of my knowledge. I give permission to Drs. Leaming and Augustus to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
 Podiatrist: \_\_\_\_\_ Date: \_\_\_\_\_

# West Coast Foot & Ankle Associates, Inc.

ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES  
(Effective Date: April 14, 2003)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice.

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Patient Name (please print)

Date

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Parent or Authorized Representative (if Applicable)

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Signature