ROPER ST. FRANCIS
PHYSICIAN PARTNERS

MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following conditions?

Diabetes	Yes ___ No ___	Alzheimer's Disease	Yes ___ No ___
Stroke	Yes ___ No ___	Anxiety	Yes ___ No ___
Arthritis	Yes ___ No ___	Depression	Yes ___ No ___
Kidney Disease	Yes ___ No ___	Heart Disease	Yes ___ No ___
Poor Circulation	Yes ___ No ___	High/Low Blood Pressure	Yes ___ No ___
Hepatitis (Liver)	Yes ___ No ___	High/Low Cholesterol	Yes ___ No ___
Back Problems	Yes ___ No ___	Bleeding Tendencies	Yes ___ No ___
Cancer	Yes ___ No ___	Varicose Veins	Yes ___ No ___
Tuberculosis (TB)	Yes ___ No ___	Respiratory Problems	Yes ___ No ___
HIV/AIDS	Yes ___ No ___	Neuropathy	Yes ___ No ___
Stomach/Bowel Problems	Yes ___ No ___	Ulcers of the foot/leg	Yes ___ No ___

Do you have any **ALLERGIES** to (Please circle): Latex Adhesive Tape Aspirin Codeine Iodine Novocain Penicillin Sulfa Other: _____

Is there any family history of (Please Circle):

Diabetes: Mother/Father/Brother/Sister
High Blood Pressure: Mother/Father/Brother/Sister
Stroke: Mother/Father/Brother/Sister
Cancer: Mother/Father/Brother/Sister
Heart Problems: Mother/Father/Brother/Sister
Poor Circulation: Mother/Father/Brother/Sister

Please explain your foot problem(s) and how long it has been present: _____

Is it a result of an injury? Yes ___ No ___ If yes, when and where did the accident occur? _____
_____

Have you ever had any type of surgeries? If so, please list _____

Do you smoke? Yes ___ No ___ If so, how many packs a day? _____
Do you consume alcoholic beverages? Yes ___ No ___ If so, how much in a week? _____

Please list all medications you currently are taking, whether they are prescription or over-the-counter:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name:_____ Date:_____

Have you ever been treated for any of the following? Fill in the Circles completely:

Heart problems	O Yes	O No
Circulatory problems	O Yes	O No
Jaundice	O Yes	O No
Stomach ulcers	O Yes	O No
Thyroid problem	O Yes	O No
Stroke	O Yes	O No
Asthma	O Yes	O No
Cardiac pacemaker or defibrillator	O Yes	O No
Arthritis	O Yes	O No
Anemia	O Yes	O No
Emphysema	O Yes	O No
Seizures	O Yes	O No
Cancer	O Yes	O No
AIDS/HIV	O Yes	O No
Kidney problems	O Yes	O No
Gout	O Yes	O No
Hearing problems	O Yes	O No
TB or exposure to TB	O Yes	O No
Coughing up blood	O Yes	O No
Depression	O Yes	O No
Pregnant	O Yes	O No
Regular menses	O Yes	O No
Diabetes	O Yes	O No
Take insulin?	O Yes	O No
How long?	O Six months	O Less than a year
	O More than a year	O Other_____