

Medical History

What foot or ankle problem brings you to our office? _____

Have you been treated by another podiatrist Yes / No The reason for care? _____

Name of the former podiatrist _____

Past Medical History

Please check "Yes" or "No" to indicate if you have had any of the following problems:

	Yes	No		Yes	No
Diabetes?	_____	_____	Lungs (Pneumonia, TB, Shortness of breath)?	_____	_____
Circulation, Swelling feet or ankles, Skin?	_____	_____	Liver / Gall bladder disease?	_____	_____
Numbness, Cramping of feet?	_____	_____	Stomach?	_____	_____
Anemia?	_____	_____	Arthritis?	_____	_____
Asthma, Allergies, Hay Fever?	_____	_____	Headaches?	_____	_____
Psychiatric?	_____	_____	Vision / Hearing?	_____	_____
Stroke?	_____	_____	Recent weight loss?	_____	_____
Heart?	_____	_____	Gout?	_____	_____
Mitral valve prolapse / Heart murmur?	_____	_____	Bleeding, Scarring tendencies?	_____	_____
High blood pressure?	_____	_____	Low back pain?	_____	_____
Thyroid?	_____	_____	HIV positive?	_____	_____
			Do you smoke?	_____	_____
			Do you consume alcohol?	_____	_____

Please list any other illnesses or problems:

Please list any past surgeries:

Current prescription medications:

Current non-prescription medications/supplements:

Allergies to medications:

Family History:

Please indicate which of your immediate relatives have had any of the following diseases:

Cancer _____

Heart Trouble _____

Kidney Disease _____

Stroke _____

Diabetes _____

High Blood Pressure _____

Arthritis _____

Additional Comments: _____

Patient Signature _____

Date _____

**Ankeny Foot & Ankle Specialists
Cervetti & Associates
110 NW Ninth, Suite 5
Ankeny, Iowa 50021**