COMPLETE FEET & ANKLE CARE

Address: 2905 W. Warner Road Ste #20 Chandler, AZ 85224
Phone: 480-933-0801
Fax: 480-933-0476
URL: www.greggkrahndpm.com

MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

Describe in your own words your Foot/Ankle problems: _____

Medical or Health Problems: _____

Hospitalizations/Surgeries: _____

Regular medications (including aspirin) Dosage: _____

Are you in good health? ❑Yes ❑No
Do you have Arthritis? ❑Yes ❑No
Are you Pregnant or Nursing? ❑Yes ❑No
Do your feet get tired at the end of the day? ❑Yes ❑No
Do you have low back Pain? ❑Yes ❑No

Family History:

High Blood Pressure	❑Yes ❑No	❑Father ❑Mother
Heart disease	❑Yes ❑No	❑Father ❑Mother
Diabetes	❑Yes ❑No	❑Father ❑Mother
Foot problems	❑Yes ❑No	❑Father ❑Mother

If you have the following, or have had, please check: (√)

❑Yes ❑No Allergies
❑Yes ❑No Anemia
❑Yes ❑No Arthritis
❑Yes ❑No Asthma
❑Yes ❑No Blood Disease/Bleeding Problems
❑Yes ❑No Cramps or numbness in feet or legs
❑Yes ❑No Diabetes
❑Yes ❑No Digestive problems
❑Yes ❑No Emphysema
❑Yes ❑No Gout Yes
❑Yes ❑No Heart Problems
❑Yes ❑No Hepatitis
❑Yes ❑No High Blood Pressure
❑Yes ❑No High Cholesterol
❑Yes ❑No HIV/AIDS
❑Yes ❑No Kidney Disease/Stones
❑Yes ❑No Liver Trouble
❑Yes ❑No Migraines
❑Yes ❑No Phlebitis (blood clots in legs)
❑Yes ❑No Rheumatic Fever
❑Yes ❑No Stroke
❑Yes ❑No Sweling in ankles or feet
❑Yes ❑No Varicose veins

I have a reaction to, or I am allergic to:

❑Yes ❑No Anesthetics (local)
❑Yes ❑No Aspirin
❑Yes ❑No Codeine
❑Yes ❑No Eggs
❑Yes ❑No Ibuprofen/Motrin/Advil
❑Yes ❑No Iodine
❑Yes ❑No Latex
❑Yes ❑No Metals
❑Yes ❑No Nail Polish
❑Yes ❑No Penicillin
❑Yes ❑No Polyester
❑Yes ❑No Sulfa
❑Yes ❑No Tape

Other: _____

Other: _____

Do you smoke or chew tobacco? ❑Yes ❑No packs per day? _____ For how many years? _____
Do you drink alcohol? ❑Yes ❑No _____ Drinks per Day, Week, Socially, Holidays
Do you have any addictions? ❑Yes ❑No Drugs _____ Alcohol _____ Other _____
Height: _____ Weight: _____ Patient Signature: _____ Shoe Size: _____

OFFICE USE ONLY: **PATIENT SIGNATURE** _____ **DATE** _____

Physician: _____ Vital Signs: BP _____ Pulse _____ Resp _____ Temp _____

Interviewer: _____