MEDICAL HISTORY

Patient Name _____

Present Complaint_____

How long has it bothered you_____

Have you been to a foot specialist before? (circle one) YES NO
If YES, to whom_____

Have you ever been treated by a Doctor for any of the following illnesses:

AIDS/HIV	Y	N	HIGH BLOOD PRESSURE	Y	N
ARTHRITIS	Y	N	LIVER DISEASE	Y	N
ASTHMA	Y	N	LEG CRAMPS	Y	N
BLEEDING PROBLEMS	Y	N	NEUROLOGICAL PROBLEMS	Y	N
BOWEL DISORDER	Y	N	PHLEBITIS	Y	N
CANCER	Y	N	RESPIRATORY DISEASE	Y	N
RHUEMATIC FEVER	Y	N	CIRCULATION PROBLEMS	Y	N
DIABETES	Y	N	SEIZURES	Y	N
EPILEPSY	Y	N	STOMACH ULCERS	Y	N
STROKE	Y	N	FRACTURES (broken bones)	Y	N
GOUT	Y	N	THYROID PROBLEMS	Y	N
HEPATITIS	Y	N	TUBERCULOSIS	Y	N
HEART DISEASE	Y	N	WARTS	Y	N

Height _____ Weight_____ Shoe Size _____ Left/Right Handed

Do you smoke or use tobacco? YES NO If YES, how long _____
Do you use non prescribed drugs? YES NO If YES, list_____

Do you drink: Coffee_____ Tea_____ Carbonated Beverages_____ Alcohol_____

Is there a family history of any diseases? None____ If so, what are they: _____
_____

List all Medications you are currently taking: _____
_____

List all Medications you are ALLERGIC to: _____
_____

List all surgical history:_____
_____

Please list additional medical information you think Dr. Leonetti should be aware of:
_____

I HEREBY GIVE PERMISSION TO DR. LEONETTI TO EXAMINE AND TREAT MY PODIATRIC PROBLEMS. I CLEARLY UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME I give permission for Dr Leonetti to give information to referring Doctor and or any Doctor we may refer you to.

Signature _____ Date_____