AllCare Foot & Ankle Center, PA
Michael V. Tran, DPM

Patient Medical History

Patient's Name: ______________________________ Age: __________

Height: ___________ Weight: __________ Shoe Size: _______

What conditions are you being seen for today? ______________________________

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Where is it located? ____

How long have you had it? ____

What started it or makes it worse? ____________________________________

What makes it better? ____

What treatments have you had and by who? _______________________________

____

Have you ever been treated by another podiatrist?_____________

If so, who, for what condition and when? ____________________________

____

Medical History Review: Do you have a history of any of the following?

___ Diabetes Type 1	___ Hepatitis/Liver Disorder	___ Arthritis	___ Stroke
___ Diabetes Type 2	___ Heart Problems	___ Cancer	___ Glaucoma
___ Kidney Disease	___ Circulation Problems	___ Paralysis	___ Blood Clots
___ Tuberculosis	___ High Blood Pressure	___ Gout	___ Thyroid Disorder
___ Rheumatic Fever	___ HIV positive	___ Phlebitis	_____ Last Tetanus Immunization

Review of Systems: Have you recently had any of the following conditions?

___ Currently Pregnant	___ Excessive Bleeding	___ Poor Healing	___ Excessive Fatigue
___ Anemia	___ Large Weight Gain	___ Shortness of Breath	___ Frequent Headaches
___ Problems Hearing	___ Sinus Problems	___ Chest Pain	___ Excessive Coughing
___ Frequent Urination	___ Leg Swelling	___ Joint Pain/Stiffness	___ Frequent Thirst
___ Varicose Veins	___ Leg Cramps	___ Back Pain	___ Muscle Weakness
___ Swollen Glands	___ Keloids	___ Skin Rashes	___ Frequent Anxiety
___ Depression	___ Numbness	___ Psychiatric Problem	___ Dizziness

___ Other (List): ____

Please list family doctor and other doctors you are currently seeing and last date of visit.

____

____

Please list all previous significant Hospitalizations / Injuries along with dates.

____

____

Past Surgical History and Dates:

____

____

Current Medications: (Please list dosage and reason for taking)

____

____

Allergies:

___ Novacaine ___ Aspirin ___ Codeine ___ Iodine ___ Metal ___ Other Antibiotics:_________

___ Penicillin ___ Sulfa ___ Tape/Band-Aids ___ Other (medication, foods, etc) ________

Social History: (please circle)

Marital Status: Single Married Divorced Separated Widowed

Alcohol Use: Never Occasional Moderate Daily

Tobacco Use: No Yes If so, how much and for how long: _______________

Recreational Drug use: Never Rare Daily

List activities that you participate in (sports, running, etc) ________________________

Family History: Please list diseases common to your family such as diabetes, heart disease, high blood pressure, arthritis, etc.

Father:____

Mother: ____

Children: ____

Siblings:____

Grandparents: ____

Signature:_________________________________ Date:_______________