Please Use **BLACK INK** To Complete Forms

Thank You For Choosing Canonsburg Podiatry Associates Chart #_____

First Name M.I. Last Name Occupation

_____ _____

Who recommended our office? Sex Age Date Of Birth Shoe Size Weight Height

_____ M / F _____ _____/_____/_____ _____ _____Lbs. _____Ft. _____In.

Phone Numbers Patient Address Who is you Primary Care Physician?

Home (_____) _____ _____ _____

Mobile (_____) _____ _____ Date Last Seen _____/_____/_____

Email _____ _____ _____ PCP Phone Number _____-_____-_____

MEDICAL HISTORY

• **Have You Ever Been Treated For:** (Check All That Apply)

__ Ankle Sprain
__ Arch Pain
__ Athletes Foot
__ Broken Foot Bones
__ Bunions
__ Childhood Foot Problem
__ Corns / Callouses
__ Leg / Foot Cramps
__ Foot Numbness
__ Fungal Nails
__ Gait Problems
__ Hammertoes / Mallets
__ Heel Pain
__ Ingrown Nails
__ Knee Pain
__ Leg / Foot Ulcers
__ Lower Back Pain
__ Neuroma
__ Rash
__ Warts

Of Childbirths _____ Are You Currently Pregnant? Y N
Are You Slow To Heal After Cuts? Y N
Do You Smoke? Y N _____Packs/Day For _____Years
If You Quit, When? _____
Alcoholic Beverages? No Rarely Moderately Daily Quit
Recreational Drugs? No Rarely Moderately Daily Quit

• **Do You Have Or Have You Ever Been Treated For:** (Check All That Apply)

__ Alzheimer's
__ Anemia
__ Arthritis
__ Asthma
__ Cancer
__ COPD
__ Congestive Heart
__ Epilepsy
__ Eye Problems
__ Glaucoma
__ Gout
__ Headaches
__ Hearing Difficulty
__ Heart Attack
__ Heart Disease
__ Hepatitis A / B / C
__ HIV / AIDS
__ High Blood Pressure
__ Kidney Disease
__ Keloids / Thick Scars
__ Liver Disease
__ Lung Disease
__ Osteo Arthritis
__ Osteoporosis
__ Phlebitis
__ Poor Circulation
__ Sickle Cell
__ Stomach Ulcers
__ Stroke
__ Thyroid Disease
__ Tuberculosis
__ Vascular Disease
__ Varicose Veins
__ Venereal Disease
__ High Cholesterol
__ Anxiety/Depression

Are You Diabetic? Y N If Yes, For How Long?_____Yrs.
Controlled With: ___Insulin ___Medication ___Diet
Last Blood Sugar Reading_____
Last Hgb A1C _____
Dr. managing your Diabetes _____
Date you last saw your doctor? _____/_____/_____

Other_____
Is this related to an accident or work injury ___Yes ____No
If yes, Date of accident or injury ____/_____/_____
Name of Company _____
Claim Number _____

• **Please Check Yes Or No:**

Do you have vascular grafts? ❑ Yes ❑ No
Do you have joint implants? ❑ Yes ❑ No
Do you have replacement heart valves? ❑ Yes ❑ No
Are you now under active chemotherapy? ❑ Yes ❑ No
Are you on blood thinners? Plavix / Aspirin / Coumadin ❑ Yes ❑ No
Do you experience abnormal bruising, bleeding or scarring? ❑ Yes ❑ No

• **Please List Any Other Medical Or Physical Problem(s) Not Noted Above:** ❑ None

_____

_____

_____

PMHX reprint

____ NO CHANGES

____ CHANGES MARKED IN RED

_____/Date_____

Patient signature for reviewed PMHX

_____/Date_____

Staff Initials/ Doctor Initials

_____

Patient Signature Date

_____

Parent/Guardian Signature Relationship To Patient

_____ _____

Staff Initials Date

_____ _____

Doctor Date

Canonsburg Podiatry Associates Chart #_____

First Name M.I. Last Name

_____

• **MEDICATIONS**—Are You Currently Taking Any Medication(s)? ❑ Yes ❑ No (If Yes, List Medication, Dose, What used for)

Medication	**Dosage**	**What is medication treating?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

• **ALLERGIES—**Do You Have A History Of Skin Reaction Or Other Outward Reaction Or Sickness Following Injection, Oral Or Topical Administration Of The Following: (If You Check Yes, Briefly Describe What Happens.)

	Y	**N**	
Penicillin	❑	❑	_____
Other Antibiotics (List Below)	❑	❑	_____
Morphine	❑	❑	_____
Codeine	❑	❑	_____
Demerol	❑	❑	_____
Other Narcotics (List Below)	❑	❑	_____
Aspirin	❑	❑	_____
Empirin / Tylenol (Circle One)	❑	❑	_____
Advil / Aleve / Motrin (Circle One)	❑	❑	_____
Other Pain Remedies (List Below)	❑	❑	_____
Sulfa Drugs	❑	❑	_____
Adhesive Tape	❑	❑	_____
Shrimp / Iodine / Betadine (Circle One)	❑	❑	_____
Any Other Medications	❑	❑	_____
Latex	❑	❑	_____
Others (List)	❑	❑	_____

• **SURGERY—**Have You Ever Had Any Surgery? ❑ Yes ❑ No (If Yes, Please List Below)

Had Surgery For:	Date:	With Complications Of:	
_____	_____	_____	❑ None
_____	_____	_____	❑ None
_____	_____	_____	❑ None
_____	_____	_____	❑ None
_____	_____	_____	❑ None

• **PREDISPOSITION**—List Your Relationship (Mother/Father/Sibling/Grandparent) To Family Members Who Have Or Had:

Diabetes_____ Foot Problems_____
Arthritis_____ Heart Attack_____
Stroke _____ High Blood Pressure_____
Cancer _____ Birth Defects_____

• **Is There Anything Else You Want The Doctor To Know?** ❑ Yes ❑ No Illnesses/Explanations: _____

_____

What may we help you with today? _____

PMHX reprint
____ NO CHANGES
____ CHANGES MARKED IN RED
_____/Date_____
Patient signature for reviewed PMHX

_____/Date_____
Staff Initials/ Doctor Initials

_____
Patient Signature Date

_____
Parent/Guardian Signature Relationship To Patient

_____ _____
Staff Initials Date

_____ _____
Doctor Date