Midwest Orthopedic Foot & Ankle, PC

PAST MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

List all past operations *Year* *Outcome*

_____

_____

_____

_____

Do you have a history of:

Heart Disease	YES ❑ NO ❑
Cancer	YES ❑ NO ❑
Diabetes	YES ❑ NO ❑
Bleeding Ulcer	YES ❑ NO ❑
Blackout/Fainting	YES ❑ NO ❑
Epilepsy	YES ❑ NO ❑
Digestion/Stomach	YES ❑ NO ❑
Rheumatoid Arthritis	YES ❑ NO ❑
Polio	YES ❑ NO ❑
TB	YES ❑ NO ❑
AIDS	YES ❑ NO ❑
Hepatitis	YES ❑ NO ❑

Do you have problems with:

Lungs/Breathing	YES ❑ NO ❑
Stomach Problems	YES ❑ NO ❑
High Blood Pressure	YES ❑ NO ❑
Bleeding/ Blood clots	YES ❑ NO ❑
Eyes	YES ❑ NO ❑
Ears/Nose/Throat	YES ❑ NO ❑
Bowel movement	YES ❑ NO ❑
Bladder	YES ❑ NO ❑
Numbness/Tingling	YES ❑ NO ❑
Balance	YES ❑ NO ❑
Psychological	YES ❑ NO ❑
Other _____	

Please explain if you checked yes to anything above: _____

_____

_____

Please list all medications you are currently taking:

Medicine	**Dose**	**Frequency**	**For what illness**

List any allergies to medications or food and adverse reactions:

_____

_____

Do you smoke? YES ❑ NO ❑ How many cigarettes per day? _____

Do you drink alcohol? YES ❑ NO ❑ How many drinks per week? _____

Has any family member had a history of serious illness? YES ❑ NO ❑

If yes, please describe: _____

Has any member of your family been seen in our office before? YES ❑ NO ❑

If so, who? _____

Occupation: _____

How long have you worked there? _____

Hobbies (optional) _____

Physician's Signature: _____