Los Gatos Foot & Ankle Center

Dr. Joan Oloff, D.P.M., F.A.C.F.A.S., M.S

Name: ____DOB____/____/______Today's Date:_______________

MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following condition?

YES___NO___ Alzheimer's ___Dementia Disease
YES___NO___ Arthritis (Painful, swollen joints) what body part: ____________________ Rheumatoid YES / NO
YES___NO___ Bleeding Tendencies with surgery or cuts? Do you take any blood thinner's: YES / NO
YES___NO___ Cancer; Explain: ____
YES___NO___ Heart Problems: [Congestive Heart Failure: YES/NO] [Heart Attack: YES/NO] [heart Arrhythmia: YES/NO]
YES___NO___ Diabetes [If YES, CIRCLE ONE: Food Controlled, Tablet or Insulin] Type1___ Type2___
YES___NO___ Neurological problems or Seizures, Explain: ____
YES___NO___ Hyperlipidemia (High Cholesterol)
YES___NO___ Hypertension: Abnormal Blood Pressure: Circle one: High or Low
YES___NO___ Kidney Problems: Explain: ____
YES___NO___ Disease's ___Liver ___ Hepatitis___ Jaundice
YES___NO___ Neuropathy
YES___NO___ Poor Circulation
YES___NO___ Respiratory Conditions (Lung or Breathing Problems) Explain: ______________________________
YES___NO___ Spine Disorders or Back Pain
YES___NO___ Stomach or Bowel Problems (if Yes, Explain: ____
YES___NO___ Stroke Date(s):____
YES___NO___ Ulcer of foot or leg (if yes, Explain, ____

YES___NO___ Other Medical Problems (if yes, Explain: ____

Do you have **ALLERGIES** to any of the following? (Please circle all that apply): Latex Adhesive Tape Aspirin Codeine Iodine Novocain Penicillin Sulfa NSAID'S Percocet Shellfish Other: ____________________

Do you have a **FAMILY HISTORY** of any of the following? (Please circle all that apply):
Diabetes: Mother / Father / Brother / Sister
High Blood Pressure: Mother / Father / Brother / Sister
Cancer: Mother / Father / Brother / Sister
Heart Problems: Mother / Father / Brother / Sister
Stroke: Mother / Father / Brother / Sister
Poor Circulation: Mother / Father / Brother / Sister

Please explain your foot problem(s) and how long has it been present?__________________________________
____
Is your foot problem a result of an accident or injury? YES___NO___ if yes, please answer the following:
When did the accident / injury occur? (Need specific date) ______________________________________
Where did the accident / injury occur? ____
Have you ever had any type of **SURGERY?** If so, please list ____________________________________
____

Do you smoke? YES___NO___ if so, how many packs a day? _______
Do you consume alcoholic beverages? YES___NO___ if so, how much in week? _________________________
FEMALES ONLY: Are you Pregnant? YES___NO___

Please list all **MEDICATIONS** you are currently taking, whether they are prescribed or over-the-counter:

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

OFFICE USE ONLY: HT: _____ WT: ______ SHOE SIZE: ______ BP: ______/______ PULES: ____ RESP: ____ TEMP:____