## **Los Gatos Foot & Ankle Center**

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

MEDICAL HISTORY  Have you ever been diagnosed or treated for any of the following condition?  YES_NO_Alzheimer's _Dementia Disease  YES_NO_Bleeding Tendencies with surgery or cuts? Do you take any blood thinner's: YES / NYES_NO_Bleeding Tendencies with surgery or cuts? Do you take any blood thinner's: YES / NYES_NO_Cancer, Explain:  YES_NO_Heart Problems: [Congestive Heart Failure: YES/NO] [Heart Attack: YES/NO] [heart AYES_NO_Diabetes [If YES, CIRCLE ONE: Food Controlled, Tablet or Insulin] Type1_Type2_YES_NO_Neurological problems or Seizures, Explain:  YES_NO_Hypertension: Abnormal Blood Pressure: Circle one: High or Low  YES_NO_Hypertension: Abnormal Blood Pressure: Circle one: High or Low  YES_NO_Hypertension: Abnormal Blood Pressure: Circle one: High or Low  YES_NO_Neuropathy  YES_NO_Poor Circulation  YES_NO_Poor Circulation  YES_NO_Poor Circulation  YES_NO_Stroke Date(s):  YES_NO_Stroke Date(s):  YES_NO_Stroke Date(s):  YES_NO_Ulcer of foot or leg (if yes, Explain:  YES_NO_Ulcer of foot or leg (if yes, Explain:  Do you have ALLERGIES to any of the following? (Please circle all that apply): Latex Adhesive Tacdeine 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  Cancer: 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 folk When did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did t	)ate:
YES_NO_Alzheimer'sDementia Disease YES_NO_Arthritis (Painful, swollen joints) what body part: Rheumatoid 'YES_NO_Bleeding Tendencies with surgery or cuts? Do you take any blood thinner's: YES / NYES_NO_Cancer; Explain:	
YES_NO_Arthritis (Painful, swollen joints) what body part:	
YES_NO_Bleeding Tendencies with surgery or cuts? Do you take any blood thinner's: YES_NO_S NO_Cancer; Explain: YES_NO_Cancer; Explain: YES_NO_Heart Problems: [Congestive Heart Failure: YES/NO] [Heart Attack: YES/NO] [heart AYES_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_Hyperlipidemia (High Cholesterol) 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_Poor Circulation YES_NO_Spine Disorders or Back Pain YES_NO_Spine Disorders or Back Pain YES_NO_Spine Disorders or Back Pain YES_NO_Stroke Date(s): YES_NO_Ulcer of foot or leg (if yes, Explain: YES_NO_Ulcer of foot or leg (if yes, Explain: YES_NO_Ulcer of foot or leg (if yes, Explain: Do you have ALLERGIES to any of the following? (Please circle all that apply): Latex_Adhesive Taccers Mother / Father / Brother / Sister Do you have a FAMILY HISTORY of any of the following? (Please circle all that apply): Diabetes: Mother / Father / Brother / Sister Cancer: Mother / Father / Brother /	
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YES_NO_ Heart Problems: [Congestive Heart Failure: YES/NO] [Heart Attack: YES/NO] [heart Attack: YES/NO] [heart Attack: YES/NO] Diabetes [If YES, CIRCLE ONE: Food Controlled, Tablet or Insulin] Type1 Type2 YES_NO_ Neurological problems or Seizures, Explain:	S / NO
YES_NO_ Heart Problems: [Congestive Heart Failure: YES/NO] [Heart Attack: YES/NO] [heart AYES_NO_ Diabetes [If YES, CIRCLE ONE: Food Controlled, Tablet or Insulin] Type1 Type2YES_NO_ Neurological problems or Seizures, Explain: YES_NO_ Hyperlipidemia (High Cholesterol) YES_NO_ Hypertension: Abnormal Blood Pressure: Circle one: High or Low YES_NO_ Hypertension: Abnormal Blood Pressure: Circle one: High or Low YES_NO_ Hypertension: Abnormal Blood Pressure: Circle one: High or Low YES_NO_ Hypertension: 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_ Stroke Date(s): YES_NO_ Stroke Date(s): YES_NO_ Ulcer of foot or leg (if yes, Explain: 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 Tacodeine 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 Cancer: Mother / Father / Brother / Sister High Blood Pressure: Mother / Father / Brother Stroke: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother Stroke: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father / Brother / Sister Poor Circulation: Mother / Father /	
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_ Spine Disorders or Back Pain  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 Tacodeine 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  Cancer: Mother / Father / Brother / Sister  Cancer: Mother / Father / Brother / Sister  Cancer: Mother / Father / Brother / Sister  Poor Circulation  When did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  Where did the accident / injury occur? (Need specific date)  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-company.	art Arrhythmia: YES/N
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_ Poor Circulation YES_NO_ Spine Disorders or Back Pain YES_NO_ Spine Disorders or Back Pain YES_NO_ Stomach or Bowel Problems (if Yes, Explain: YES_NO_ Stomach or Bowel Problems (if Yes, Explain: 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 Touchein Indian 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 Cancer: Mother / Father / Brother / Sister Cancer: Mother / Father / Brother / Sister Cancer: Mother / Father / Brother / Sister Please explain your foot problem a result of an accident or injury? YES_NO_ if yes, please answer the foliow of the problems are sult of an accident or injury? YES_NO_ if yes, please answer the foliow of the problem of the accident / injury occur? (Need specific date) Where did the accident / injury occur? (Need specific date) Where did the accident / injury occur? (Need specific date) Do you smoke? YES_NO_ if so, how many packs a day? 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-centers.	2
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