adler podiatry clinic+

Patient Medical Information

Patient Name: _____ Date: ___/___/____

Date of Birth: ___/___/_____ Age: ____ Male ____ Female ____

Email: _____ Pharmacy: _____

Primary Care Physician:_____

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What foot problem(s) are you having? _____

_____

When did it start? _____ Ever had similar problem(s)? Y__N__

Was it treated? Y__N__ When? _____ By whom? _____

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Allergies? Penicillin ___ Aspirin ___ Codeine ___ Novocain ___ Sulfa ____

Tape___ Iodine __ Other _____

List all Current Medications: _____

_____

Operations:_____

_____

Injuries: _____

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What is your Height? ___ Weight ___ Do you Smoke? Y__N__ Use Alcohol? Y__N__

Please tell us if you have any Medical Problems:

Diabetes__ Poor Circulation__ Arthritis__ Stomach__ Seizures__ Thyroid__ Bone__

Cancer__ Heart__ Blood Pressure__ Liver__ Lung__ Kidney__ Breathing__ Blood__

Bleeding__ Muscle__ Immune Disorders__ Nerve__ Medical, Physical, Emotional __

Other_____

Female Patients: **Is there a chance of Pregnancy? Y___ N____**

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