adler podiatry clinic

Patient Name: Date of Birth: Date:

What foot/ankle problem(s) are you having?

When did it start? ☐ Previously had similar problem(s) ☐ It was Treated

When? By whom?

**ALLERGIES** ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Novacaine ☐ Sulfa ☐ Tape

**MEDICATIONS** ☐ Diabetes ☐ Blood Thinner ☐ Blood Pressure ☐ Arthritis ☐ Heart

**CURRENT MEDICATIONS**

**OPERATIONS**

**INJURIES**

**Height** **Weight** **Age** Do you smoke? ☐ Packets/Day Use Alcohol ☐

**Have you ever been Treated for any of the following Medical Conditions?**

☐ Diabetes ☐ Poor Circulation ☐ Arthritis ☐ Stomach ☐ Blood Pressure ☐ Liver ☐ Thyroid

☐ Muscle ☐ Immune Disorders ☐ Nerve ☐ Mental/Emotional ☐ Seizures ☐ Cancer ☐ Bleeding

☐ Other Medical Conditions

Female Patients: ☐ Pregnancy Name of Primary Care Physician

**Email: myfootdoctor@adlerpodiatry.com Fax: (904) 731-9270 or Bring to Appointment**