

PATIENT MEDICAL HISTORY

WHO IS YOUR PERSONAL PHYSICIAN? _____

PHARMACY: *(Name, address, city)* _____

HOW IS YOUR GENERAL HEALTH? _____

HEIGHT: _____

WEIGHT: _____

FAMILY MEDICAL HISTORY: _____

LIST OF SURGERIES: _____

ARE YOU DIABETIC?*(Circle)* Yes No **DO YOU SMOKE?***(Circle)* Yes No **DO YOU DRINK ALCOHOL?***(Circle)* Yes No

Please list any medical problems: _____

MEDICATIONS

Please list any medications or drugs you take: _____

ALLERGIES

Please list any medications that you are allergic to: _____

PODIATRIC HISTORY

WHAT IS THE REASON FOR THE VISIT? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HAVE YOU BEEN TREATED FOR THIS CONDITION BEFORE?*(Circle)* Yes No

DOCTOR'S NAME: _____

LAST VISIT: _____

HAVE YOU HAD PREVIOUS FOOT SURGERY?*(Circle)* Yes No _____

Please indicate which foot problems you have had in the past: _____

I certify that the above information is true and correct to the best of my knowledge. I give permission to Heamin T. Shin, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet (or that of y minor child or dependent).

Print name _____

Patient signature _____

Date: _____

Legal Guardian (if patient is a minor) _____

Date: _____