

Patient Registration/Medical History

Milford Podiatry Associates, PC

Welcome To Our Practice

Please take time to carefully answer the following questions to the best of your knowledge.

You may complete the form and bring it with you for your office visit. Thank you.

Your Name: _____ / _____ / _____ Date: _____
Last First MI

What is the reason for today's visit? _____

How long have you had this problem? _____

Have you seen any other medical professionals for treatment for this problem? No Yes

Physician's Name: _____

Treatment Offered: _____

Have you done any home treatment for the problem yourself? No Yes

What treatment? _____

Is a medical professional treating you for other medical problems? No Yes

(example: diabetes, high blood pressure, arthritis, etc.)

Problem: _____

Are you taking any prescription medications? No Yes

Name/Dose: _____

Are you taking any non-prescription medications? No Yes

Name/Dose: _____

Have you ever had an allergic reaction to any medication? No Yes

Name/Reaction: _____

Do you smoke? No Yes How much daily? _____

Do you drink alcohol? No Yes (circle) Daily / Weekly / Monthly

Do you use any other illegal or legal drugs? No Yes

Have you ever had an operation or been hospitalized? No Yes

Procedure(s)/Date: _____

Hospital/Date: _____

Do you have a family history of medical conditions that affected your mother, father, brother(s) or sister(s)? No Yes

Describe: _____

Do you have a history of any of the following medical problems?

- | | | | | | |
|---------------------------|-----------------------------|------------------------------|--------------------------------|-----------------------------|------------------------------|
| 1. Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 15. Swelling in feet or ankles | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Numbness in feet | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 16. High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Cramps in legs or feet | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 17. Strokes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Circulation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 18. Fainting or Convulsions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 19. Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Joint Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 20. Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Gout | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 21. Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Bleeding Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 22. Hay Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Stomach Ulcers | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 23. Lungs/Pulmonary | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Kidney Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 24. Thyroid | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Liver or Gallbladder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 25. Skin Disorders | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 26. Trouble with vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. Chest Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 27. Trouble with hearing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 14. Shortness of Breath | <input type="checkbox"/> No | <input type="checkbox"/> Yes | 28. Mental Illness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If you answered yes to any of the above items please write the number next to the item checked and give a brief explanation:

Item#	Explanation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____