Mindy E. Lam, DPM 870 Route 146, Clifton Park, NY 12065 (P) 518-371-7133 (F) 518-371-7135

MEDICAL HISTORY FORM

Name: ____ **Age:** _______ **Shoe Size:** ______________________

Height: ________________ **Weight:** __________________________

What is the chief complaint for which you came to be treated? ____

How long have you had this problem? ____

What is your level of pain? (0 no pain, 10 extreme pain) ____

Have you ever been treated for this before? ◯Yes ◯No

Have you ever been to a Podiatrist before? ◯Yes ◯No If yes, please list. **Name**: ______________________________

MEDICAL HISTORY Place a mark on "**Yes**" or "**No**" to indicate if you have had any of the following: If yes, please explain below.

Condition		Condition		Condition	
AIDS/HIV	◯Yes ◯No	Chemical Dependency	◯Yes ◯No	High Cholesterol	◯Yes ◯No
Alzheimer's	◯Yes ◯No	Depression	◯Yes ◯No	Liver Disease(other than Hepatitis)	◯Yes ◯No
Anemia	◯Yes ◯No	Diabetes	◯Yes ◯No	MRSA	◯Yes ◯No
Anxiety	◯Yes ◯No	Foot or Leg Cramps	◯Yes ◯No	Phlebitis	◯Yes ◯No
Arthritis	◯Yes ◯No	Gastrointestinal Disease	◯Yes ◯No	Poor Circulation	◯Yes ◯No
Asthma	◯Yes ◯No	Gout	◯Yes ◯No	Respiratory Disease	◯Yes ◯No
Back Problems	◯Yes ◯No	Heart Disease	◯Yes ◯No	Swelling in Ankles, Feet	◯Yes ◯No
Bleeding Disorders	◯Yes ◯No	Hepatitis	◯Yes ◯No	Ulcers	◯Yes ◯No
Cancer	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Varicose Veins	◯Yes ◯No

Other Medical History Not Stated Above: ____
____

MEDICATIONS: Include prescriptions, over-the-counter medications, vitamins and **Dosage** of medications ______________
____
____

MEDICATION ALLERGIES WITH REACTIONS: ____
____

SURGICAL HISTORY: ____
____

SMOKING HISTORY: ____

PHARMACY NAME: __________________________ **PHARMACY ADDRESS**: ______________________________

CONSENT I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature ____ **Date**____________________