



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.

- AIDS/HIV, Alzheimer's, Anemia, Anxiety, Arthritis, Asthma, Back Problems, Bleeding Disorders, Cancer, Chemical Dependency, Depression, Diabetes, Foot or Leg Cramps, Gastrointestinal Disease, Gout, Heart Disease, Hepatitis, High Blood Pressure, High Cholesterol, Liver Disease, MRSA, Phlebitis, Poor Circulation, Respiratory Disease, Swelling in Ankles, Feet, Ulcers, Varicose Veins

Other Medical History Not Stated Above: _____

MEDICATIONS: Include prescriptions, over-the-counter medications, vitamins and Dosage of medications _____

MEDICATION ALLERGIES WITH REACTIONS: _____

SURGERIES YOU HAD _____

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 _____