adler podiatry clinic+

Philip Adler, DPM, ABPS, FACFAS
Emily Graves-Niles, DPM
Beth Pearce, DPM, FACPM
Michael Toney, DPM, ABPS, ABPOPPM

Medical History Form

Name: _____Date of Birth: _____Age: _____
Gender: _____Height: _____Weight: _____
Address: _____Phone Number: _____
PCP: _____Month/Year of Last Visit with PCP: _____
Preferred Pharmacy + Address: _____

In the past one month, have you experienced any of the following: □ N/A
□ changes in hearing/vision □ chest pain □ shortness of breath □ falls/unsteadiness
□ heat/cold intolerance □ skin rashes □ memory problems □ abdominal pain □ back pain

Please describe your current foot/ankle problem:

Duration of problem: _____

Have you previously received treatment for this problem or a similar problem? □ Yes □ No

If yes, when _____and by whom _____

Do you believe your symptoms are related to an injury: □ Yes □ No

If yes, what is the date of injury: _____and where did the injury occur? _____

Lifestyle History

What is your occupation? _____

Typical footwear-- Home: _____Work: _____

How many hours per day do you typically spend standing or walking? _____

Smoking Status: □ Nonsmoker □ Former smoker; approximate date or year quit: _____
□ Current Smoker _____packs/day

Alcohol Consumption: How many alcoholic drinks do you consume per week? ___

Pregnancy/Nursing Status: □ Not Applicable □ Pregnant □ Nursing/pumping

Medical History

Please check if you have been diagnosed with any of the following conditions:

□ Diabetes Mellitus	□ Stomach ulcers / GI bleeding	□ Autoimmune disease:
□ High blood pressure	□ Low thyroid	□ Fibromyalgia or PCOS
□ High cholesterol	□ Peripheral Edema/Leg swelling	□ Chronic pain: _____
□ Kidney disease; stage _____	□ Cancer: _____	□ Arthritis: _____
□ Heart Disease: _____	□ Arterial Disease/PVD	□ Blood clots / DVT
□ Liver Disease: _____	□ Neuropathy	□ On Blood Thinners: _____

Please list any other medical conditions not included above:

Medications: Please list all medications (and dosages) you are currently taking, including over-the-counter drugs and supplements

Previous Surgeries/Injuries:

Allergies: □ No Known Drug Allergies

□ Penicillin, reaction: _____ □ Sulfa drugs □ Lidocaine/Novacaine □ Tape

Please list any additional allergies: _____

Is there anything else you would like our doctors/staff to know?

Referral Source: How did you hear about Adler Podiatry Clinic? _____

□ Your doctor □ Family member □ Another patient □ Website □ Internet