McKenzie-Hastings Institute For Foot & Ankle Surgery Medical Information

Patient Name:____DOB:_____________________

Are you currently diabetic? **YES** or **NO**

Primary Doctor:______________________________________Phone Number:______________________

Name of Doctor that referred you to this office:____

SURGERY:
Name of Surgery Year of Surgery Complication? (if yes, please define)

____
____
____
____
____
____

FAMILY HISTORY (check all that apply):

	Mother	Father	Grandparents	Siblings	Children
Anesthesia complication					
Bleeding disorder					
Cancer (specify type)					
Diabetes					
Epilepsy					
Glaucoma					
Heart disease					
High blood pressure					
Kidney disease					
Mental illness					
Osteoporosis					
Stroke					
Thyroid disease					

SOCIAL HISTORY & LIFESTYLE:

Alcohol? **YES** or **NO**
Daily amount?_______
Type?_______________

Recreational drugs? **YES** or **NO**
Daily amount?__________
Type?__________________

Caffeine? **YES** or **NO**
Daily amount?______
Type?______________

Employer:____Do you exercise weekly? **YES** or **NO**
Job Title:___________________________________What family members live with you?____________________

Smoking (check one):
____Non-smoker (never or <100 cigarettes in a lifetime)
____Previous smoker (quit date: ___________)
____Current smoker (1-3 cigarettes per day)
____Current smoker (up to one pack per day)
____Current smoker (one to two packs per day)
____Current smoker (two or more packs per day)

MEDICATIONS:

*Please follow the example below, listing the SPECIFIC medication/strength/dose/DIAGNOSIS that is treated by the medication.

MEDICATION	STRENGTH	HOW OFTEN	DIAGNOSIS (WHY YOU TAKE MEDICATION?)
Example: Lamisil	***250 mg***	***Once daily***	***fungal toenails***

Any non-prescription therapies like vitamins or fish oil? PLEASE LIST SPECIFIC DOSAGE:

___

Circle any other medical conditions that you have, but DID NOT list in the chart above (you are NOT currently taking medications for these):

Anemia
Ankle swelling
Arthritis (osteoarthritis)
Arthritis (rheumatoid)
Arthritis (psoriatic)
Asthma
Bleeding disorder
Blood clots
Bowel disease

Cancer- type:_______
COPD
Depression
Diabetes
Diphtheria
Epilepsy
Frequent infections
Glaucoma
Gout

Heart disease
Heart murmur
Hernia
High blood pressure
High cholesterol
HIV/AIDS
Kidney disease
Liver disease
Lymphedema

Measles
Mental illness
Migraines
Mitral valve prolapse
Mumps
Rubella
Scarlet fever
Skin disease
Sleep apnea

STD- type:________
Stomach ulcers
Stroke
Thyroid disorder
Varicose veins

ALLERGIES:

_____NO KNOWN DRUG, FOOD, OR ENVIRONMENTAL ALLERGIES

DRUG ALLERGIES

Name of Drug	Location of Reaction (e.g. skin, local site, abdominal, systemic)	Specific Reaction (e.g. rash, swelling, hives, tongue swelling, cramping, shortness of breath)	Severity of Reaction (very mild, mild, moderate, or severe)
Example: penicillin	*systemic*	*tongue swelling*	*severe*

FOOD ALLERGIES

Name of Food	Location of Reaction	Specific Reaction	Severity of Reaction
Example: dairy	*abdominal*	*cramping*	*mild*

ENVIRONMENTAL ALLERGIES

Name of Allergen	Location of Reaction	Specific Reaction	Severity of Reaction
Example: dust	*localized*	*sneezing*	*very mild*

Signature:____Date:______________________