New Jersey Foot and Ankle Specialists, LLC

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MEDICAL HISTORY

Name: _____ Date Of Birth: _____

HEIGHT: _____ WEIGHT: _____ LAST BLOOD PRESSURE: _____

Primary Doctor's Name: _____ Date Last Seen:_____

Allergies:_____ ☐No allergies

Medications: ☐ See Attached List

Does any major medical disease run in your family? If so, WHICH disease, and WHO had them?

_____

Do you smoke? _____ Did you ever? _____ If so, when did you quit? _____

Did you ever have a substance abuse problem? _____ If so, what type?_____

How much alcohol do you drink? *None* *1-2 drinks/week* *1-2drinks/night* *1-2drinks/month*

Do you have Diabetes? _____ If so, which type? _____ Last BS or A1c _____

Please list any other medical problems you have had, including any surgery or hospitalizations:
(Including all organs i.e. heart, lung, kidney, liver, brain, skin, blood as well as bones, nerves, infections etc.)

_____

_____

_____

_____

Presently, do you have any active symptoms related to any of the above mentioned systems including fever, chills, nausea, vomiting, diarrhea, shortness of breath, headache, chest pain, dizziness, new rash, change in hearing or change in eyesight? If so, what symptoms?

_____

Please describe the issue which brought you here today in one sentence:

_____

Signature of Patient (or responsible guardian) x_____

Date _____

*By signing, you acknowledge the above information is true to the best of your knowledge *