Twin Cities Foot & Ankle Clinic, P.A.

MEDICAL HISTORY

PATIENT NAME	DOB
HEIGHT	WEIGHT

ILLNESSES: Have you ever had any of the following:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble / Neck Trouble
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Colitis
- ☐ Convulsion / Epilepsy
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Stone
- ☐ Migraine
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Reflux / Indigestion
- ☐ Skin Disease
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose Veins

Do you exercise? ☐ No ☐ Yes How often?

Do you smoke? ☐ No ☐ Yes Packs/Day _____ ☐ Stopped _____ ☐ Years/☐ Months ago

Do you consume alcohol? ☐ No ☐ Yes number of drinks per ☐ day/☐ week (circle one) _____

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary.)

Medication	Strength	How Often	Prescribed By	Reason

Please list known allergies and reactions to medications or substances (e.g., latex, iodine, etc.)

☐ No Known Allergies		General Anesthesia	Reaction
Antibiotics / Penicillin	Reaction	Lidocaine / Novocaine (Local Anesthesia)	Reaction
Aspirin	Reaction	Radiographic Contrast / Dye	Reaction
Band Aids / Tape	Reaction	Sedative	Reaction
Codeine	Reaction	Sulfa Drugs	Reaction
Iodine	Reaction	Latex	Reaction
Other:			Reaction
Other:			Reaction
Other:			Reaction

Please list (below) any prior surgeries you have had, including wisdom teeth removal, tonsillectomy, appendectomy, etc.

Surgery / Reason	Date	Surgery / Reason	Date