

— Neal A. Marks, D.P.M., F.A.C.F.A.S. —

Heather A. Craig, D.P.M.

William J. Scott, D.P.M.

Rocky River Office • 2880 Plymouth Avenue

South Euclid Office • 4338 Mayfield Road

Name _____ Date _____ Shoe Size _____

Reason for today's visit _____

Duration of problem: _____ Have you had previous treatment? _____

Is this injury related? _____ Date of injury: _____

Family Physician: _____ Date of last visit: _____

MEDICAL HISTORY

DO YOU HAVE OR EVER HAVE BEEN TREATED FOR THE FOLLOWING (check all that apply);

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Spinal / Disc Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Smoker _____ PPD |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |
| | | | <input type="checkbox"/> None of these |

ALLERGIES (check all that apply)

- | | | |
|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tapes / Adhesives | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Novocain | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |

FAMILY MEDICAL HISTORY

PRIOR SURGERIES

MEDICATIONS (Please include dosage and frequency)

