Clark Podiatry Center
"We Keep You Walking."

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Medical History

Name: _____ MRN: _____ (for office use)

How is your general health? ___ Good ___Fair ___Poor
Are you now, or within the past 2 years have you been under a physician's care? ___ yes ___no
If yes, what are you being treated for?

_____

_____

Medication History: Please list ***all*** medications you take: include prescription and non-prescription medications, vitamins and supplements: Please list or provide a copy of the list:

Are you allergic to medicines, adhesive tape, latex or penicillin? ___ yes ___no
Please list all allergies you have:

Surgical procedures you have had:

Hospitalizations other than for the surgeries:

Smoking history: Currently smoke: ___Yes ___No Former smoker, stopped/quit: ____ Never smoked : ____

Family Physician/Primary Care doctor: _____

Last visit date: _____ May we contact him/her regarding your care? __Yes __No

Your Pharmacy name, town: _____

If available electronically, may we obtain your medication history from the pharmacy? ___Yes ___No

Signature _____ Today's date: _____