Gadsden Foot Clinic, PC
306 South 4th Street
Gadsden, AL 35901

HEALTH HISTORY

Patient: _____ Chart # _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

- ☐ Diabetes
- ☐ Thyroid Condition
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Asthma
- ☐ COPD
- ☐ Hypertension
- ☐ Stroke
- ☐ Pneumonia
- ☐ TB
- ☐ HIV Positive
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Epilepsy
- ☐ Gastric Reflux
- ☐ Stomach Ulcers
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Arthritis
- ☐ Veneral Disease
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Cancer
- ☐ Swelling of Legs
- ☐ Thrombophlebitis
- ☐ Recent Weight Gain / Loss
- ☐ Urinary Tract Infections
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Low Back Pain

LIST ALL MEDICATIONS YOU ARE TAKING: (include birth control & non-prescription drugs)

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

☐ Novacaine ☐ Codeine ☐ Penicillin ☐ Demerol ☐ Iodine ☐ Tape

Reaction: (rash) _____

LIST ANY OTHER DRUGS YOU ARE ALLERGIC TO: _____

_____

_____

Tobacco / SMOKE? _____ How Much? _____ PPD How Long? _____ years Reformed: _____

SURGICAL HISTORY: (Operations)

- ☐ C-section
- ☐ D&C
- ☐ Hysterectomy
- ☐ Breast Biopsy
- ☐ Thyroidectomy
- ☐ Heart Angioplasty
- ☐ Open Heart Bypass
- ☐ Arthroscopy
- ☐ Joint Replacement
- ☐ Repair Fracture

Females, are you pregnant? _____

_____

_____

_____

ANY COMPLICATIONS WITH PRIOR SURGERY OR ANESTHESIA?

- ☐ Nausea/vomiting
- ☐ PostOP infection

_____

HAVE YOU BEEN HOSPITALIZED FOR ANY OTHER REASONS? ☐ Diabetes ☐ Heart Attack ☐ Stroke ☐ Congestive Heart Failure ☐ Blood clots ☐ Pneumonia

_____

DO YOU FORM KELOIDS OR THICK SCARS? _____

FAMILY HISTORY (Blood Relative):

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Cancer
- ☐ Asthma
- ☐ Psorasis
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Foot Deformity
- ☐ Gout
- ☐ Tuberculosis
- ☐ Bleeding Disorder

WOULD YOU SAY YOUR HEALTH IS:

- ◯ Excellent
- ◯ Good
- ◯ Poor

I hereby give permission to Dr. Vanore, Dr. Gorham & their staff to administer treatment and to perform minor operative procedures deemed necessary in the diagnosis and treatment of my foot condition. I understand that this office will assist me in the filing of insurance forms, however, I understand that I accept responsibility for the payment of charges for services rendered.

Date: _____ Patient Signature: _____