

**FOOT SPECIALISTS OF CEDAR PARK & GEORGETOWN**  
**MEDICAL HISTORY**

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**Allergies:** (Please circle any allergies you have.) \_\_\_\_\_ No known drug allergies.

Adhesive tape      Aspirin      Codeine      Demerol      Iodine      Local Anesthetics  
Penicillin      Sulfa      Other antibiotics \_\_\_\_\_      Other \_\_\_\_\_

**Smoking History:** ( ) Never smoked      ( ) Past smoker      ( ) Current smoker, #/day \_\_\_\_\_

**Alcohol Use:** ( ) No      ( ) Yes, how often/how many \_\_\_\_\_

**Review of Body Systems**

*Please check if you have any of the following.*

<b>Eyes:</b>	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Blindness			
<b>Musculoskeletal:</b>	<input type="checkbox"/> Pain	<input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling
	<input type="checkbox"/> Foot/Leg cramps				
<b>Integument:</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Itching		
<b>Respiratory:</b>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough		
<b>Cardiovascular:</b>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Swelling ankles/feet			
<b>Neurologic:</b>	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Dizziness	
<b>Constitutional:</b>	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	
<b>Gastrointestinal:</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Jaundice		
<b>Genitourinary:</b>	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Burning urination	<input type="checkbox"/> Discharge		
<b>Hematologic:</b>	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Excessive bruising	<input type="checkbox"/> Using blood thinners		

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent**

*I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.*

\_\_\_\_\_  
*Signature of patient or legal guardian*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*Date*