

THOMAS C.HOSEY, DPM & ASSOCIATES P.C.

MEDICAL INFORMATION:

Patient's Family Doctor: _____ Phone: _____

Please list Medications you are allergic to:

What Medications do you take regularly:

Do you have diabetes? _____ Insulin Dependent? _____

Is there a family history of diabetes? _____

List any past surgical history: _____

If you have had or have any of the following, please circle:

Heart Trouble Please explain: _____

Anemia _____

Kidney Trouble _____

Circulation Disease _____

High Blood Pressure _____

Rheumatic Fever _____

Cancer _____

Stomach Ulcers _____

Epilepsy _____

Prolonged Bleeding _____

Psychological _____

Asthma _____

Hepatitis _____

Liver Trouble _____

Aids _____

Cramps or Numbness in Feet or Legs _____

Are you pregnant? _____ Tobacco Use Yes No How Much? _____

Alcohol Consumption Yes No How Much? _____

My Foot/Ankle Problem Is: _____

How long have you had this problem? _____

Additional comments: _____

Signed: _____ **Date:** _____

If signed as Parent/guardian, state relationship to patient: _____