Fairfield Center
1881 Post Road Fairfield, CT 06824
203.255.1036 Fax 203.259.3444

Medical History Review

Date: ____________

Name: ____________

Patient Signature: ____________

Medications

- [ ] **Taking No Medications**

____
____
____
____
____

General Health

- [ ] Excellent
- [ ] Fair
- [ ] Good
- [ ] Poor

Allergies to Medications

- [ ] **No Drug Allergies**
- [ ] Allergic to Penicillin
- [ ] Allergic to Sulfa Drugs
- [ ] ____________
- [ ] ____________

Social History

Alcohol

- [ ] **None**
- [ ] Light
- [ ] Heavy

Tobacco

- [ ] **None**
- [ ] Light
- [ ] Heavy
- [ ] Still Smoking
- [ ] Quit Smoking

Number of Years: ____________

Number of Packs/day: ____________

Number of Children: ____________

Bleeding Disorders

- [ ] **No Problems**
- [ ] Anemia
- [ ] Bleeding Problem
- [ ] *Other:* ____________

Metabolic Disorder

- [ ] **No Problems**
- [ ] Diabetes
- [ ] Low Blood Sugar
- [ ] Thyroid
- [ ] *Other:* ____________

Neurologic

- [ ] **No Problems**
- [ ] Headaches
- [ ] Seizures
- [ ] Head Injury
- [ ] Depression
- [ ] Dizziness
- [ ] Stroke: [ ] R [ ] L Side
- [ ] Numbness
- [ ] *Other:* ____________

Eyes

- [ ] **No Problems**
- [ ] R [ ] L Impaired Vision
- [ ] R [ ] L Cataract
- [ ] Glasses / Contacts
- [ ] *Other:* ____________

Ears

- [ ] **No Problems**
- [ ] R [ ] L Impaired Hearing
- [ ] R [ ] L Hearing Aid
- [ ] R [ ] L Ring or Buzzing
- [ ] *Other:* ____________

Nose / Throat

- [ ] **No Problems**
- [ ] Bleeding
- [ ] Persistent Hoarseness
- [ ] Sinus Problems
- [ ] Difficult Swallowing
- [ ] *Other:* ____________

Lungs

- [ ] **No Problems**
- [ ] Asthma
- [ ] Wheezing
- [ ] Coughing up Blood
- [ ] Shortness of Breath
- [ ] Pain on Breathing
- [ ] Problem with Anesthesia
- [ ] *Other:* ____________

Heart

- [ ] **No Problems**
- [ ] Chest Pain
- [ ] History of Heart Attack
- [ ] Coronary Artery Disease
- [ ] High Blood Pressure
- [ ] Leg/Ankle Swelling
- [ ] Irregular Heart Beat
- [ ] *Other:* ____________

Gastro / Intestinal

- [ ] **No Problems**
- [ ] Ulcers
- [ ] Reflux
- [ ] Constipation
- [ ] Diarrhea
- [ ] Nausea/Vomiting
- [ ] Change in Bowel Habits
- [ ] *Other:* ____________

Gynecological

- [ ] **No Problems**
- [ ] Currently Pregnant
- [ ] Menstruation Problems
- [ ] Excess Bleeding
- [ ] Abnormal Breast Exam
- [ ] *Other:* ____________

Urinary System

- [ ] **No Problems**
- [ ] Painful Urination
- [ ] Bloody Urine
- [ ] Frequent Urination
- [ ] Difficult Urination
- [ ] History of Kidney Stones
- [ ] *Other:* ____________

Cancer History

- [ ] **No Problems**
- [ ] Lung
- [ ] Cervix
- [ ] Liver
- [ ] Ovarian
- [ ] Prostate
- [ ] Uterus
- [ ] Colon
- [ ] Bladder
- [ ] Skin
- [ ] Breast
- [ ] Bone
- [ ] Kidney
- [ ] *Other:* ____________

Past Surgeries

Past Surgeries		Date
[ ] **No Past Surgeries Performed**		
[ ] Head / Brain Surgery		____
[ ] Cataract Surgery	[ ] R [ ] L	____
[ ] Neck		____
[ ] Thyroid		____
[ ] Heart Surgery		____
[ ] Lung Surgery		____
[ ] Breast Surgery		____
[ ] Gall Bladder Removal		____
[ ] Stomach / Bowel Surgery		____
[ ] Kidney Stones		____
[ ] Appendix Removal		____
[ ] Prostate Surgery		____
[ ] Hysterectomy		____
[ ] Hemorrhoid Surgery		____
[ ] Vascular Surgery		____
[ ] *Other:* ____________		____

Musculoskeletal Surgeries

Musculoskeletal Surgeries		Date
[ ] **No Past Surgeries Performed**		
[ ] Spine Surgery		____
[ ] Shoulder Surgery	[ ] R [ ] L	____
[ ] Elbow Surgery	[ ] R [ ] L	____
[ ] Wrist / Hand Surgery	[ ] R [ ] L	____
[ ] Hip Surgery	[ ] R [ ] L	____
[ ] Knee Surgery	[ ] R [ ] L	____
[ ] Ankle / Foot Surgery	[ ] R [ ] L	____
[ ] *Other:* ____________		____

Family Health History

- [ ] **No Health Problems**
- [ ] Anesthesia Complications
- [ ] Malignant Hyperthermia
- [ ] *Other:* ____________

My Height: ______ Feet ______ Inches

My Weight: ______ Pounds

My Shoe Size: ____________

My Previous Foot Doctor: ____________

Reviewed by: Dr. ____________

Date Reviewed / Updated: ____________

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