

CAPITAL PODIATRY ASSOCIATES

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Telephone: (202) 223-0500

PATIENT'S HEALTH INFORMATION

Primary Care Physician's Name: _____

Date of Last Physical Exam: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Chief Foot Complaint: _____ Shoe Size: _____

MEDICAL CONDITIONS AND MEDICINES

HISTORY

Have You Had...

Please mark each box if the answer is yes, leave blank if the answer is no.

- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Circulatory Problems
- Rheumatic Fever
- Hepatitis
- Diabetes
- Allergies/Hay Fever
- Shortness of Breath
- Alcoholism
- Radiation Treatments
- Removal of Tonsils
- Removal of Adenoids
- Epilepsy
- Kidney Problems
- Nervous Problems
- Tuberculosis
- Excessive Bleeding
- Ulcer
- Liver Problems
- Gall Bladder
- Cerebral Palsy
- Scarlet Fever
- Malignancies
- Asthma
- Chronic Sinus Problems
- Dizziness
- Arthritis
- Gout
- A.I.D.S
- H.I.V.
- Venereal Disease
- Other

Other Health Concerns

Medication Allergies

Prescriptions

Over the Counter

Pregnancy

Are you Pregnant ?
If yes, how many months? _____

Hospitalization

Have you ever been hospitalized?
If yes, please explain _____

Immediate Family Members' History

Please list any significant medical conditions experienced by immediate family: _____

Previous Podiatric Treatment

