



Aboite Podiatry Associates, P.C.

7559 West Jefferson Blvd., Fort Wayne, IN 46804

P: 260-436-3579

F: 260-459-0287

W: www.aboitepodiatry.com

Patient Name _____

Date _____

Date of Birth _____

Occupation _____

Height _____

Weight _____

Shoe Size _____

Social History

Do you smoke? Yes (list number of packs per day) No

Do you drink alcohol? Yes (list number of drinks per day) No

Do you take any recreational drugs? Yes (list types) No

Do you actively participate in sports? Yes (list types) No

Physical History (Check all that apply)

- Aids Difficulty breathing Malaria Polio
- Alzheimer's Diphtheria Measles Raynaud's
- Anemia Epilepsy Mitral valve prolapse Rheumatic fever
- Aneurysm Glaucoma Mumps Scarlet fever
- Ankle swelling Gout Muscular weakness Sleep Apnea
- Arthritis Headaches Narcolepsy Stomach ulcer
- Asthma Hepatitis Neurological problems Stroke
- Blood clots Heart disease Osteoporosis Thyroid disorder
- Blood disorder High blood pressure Palpitations Tuberculosis
- Bleeding tendency Kidney disease Paralysis Venereal disease
- Cancer (Specify type) Liver disease Parkinson's Other (specify)
- Chicken pox Low back pain Peripheral vascular disease
- Diabetes Lupus Pleurisy
- Other/additional information

Physical History (Check all that apply)

Have you had problems with any of the following? (Circle all the apply)

- Eyes: Cataracts Macular Degeneration Glaucoma Glasses Contacts
- Head: Concussion Trauma
- Ears: Ringing of Ears Dizziness Hearing Aids Hearing Loss Meniere's
- Nose: Sinus Allergies
- Throat: Strep Throat Tonsillitis Cancer
- Lungs: Emphysema Cancer Shortness of Breath
- GI: Ulcer Intestinal Problems Crohn's GERD Irritable Bowel Syndrome
- Skin: Non-healing Sores Eczema Psoriasis
- Joints: Rheumatoid Arthritis Degenerative Arthritis Joint Implants Gout
- Muscles: Fibromyalgia Muscular Dystrophy Multiple Sclerosis

Are you pregnant? Yes No

Surgery History Please list **all** surgeries and any complications with anesthesia:

Patient Name

Date of Birth

Present Medical Conditions:

Injury History

Please list all broken bones, sprains, etc.

Do you have any pins, screws, plates, or implants?

Yes (list)

No

Do you have any joint replacements?

Yes (list)

No

Do you have a heart pace maker?

Yes (list)

No

Family History

(check all that apply)

Arthritis

High blood pressure

Blood disorder

Kidney disease

Cancer

Liver disease

Diabetes

Other (specify)

Foot disorder

Heart disease

Present Medications

Please list all medications, amounts and frequency taken. Please include all over-the-counter medicines (ie: Ginkoba, Aspirin, Vitamins)

Allergies or Medicines Not Tolerated

Please list all known allergies and the **type of reaction:**

Family Doctor:

Date of Last Visit:

Cardiologist:

Date of Last Visit:

Endocrinologist:

Date of Last Visit:
