MERCADO FOOT & ANKLE CENTER

PATIENT MEDICAL INFORMATION

Patient Last Name______________________________ First Name______________________________

Date of Birth_______________

List Medical Problems Or Surgeries ________ List Medications Currently On ____________

____ ____

____ ____

____ ____

Do you or your family have a history of (check if yes to all that apply.)

	Self	Family		Self	Family
Coronary Artery Disease			Cancer		
Diabetes			Gastrointestinal Disease		
Stroke			Neurological Disease		
Vein or Artery Disease			High Blood Pressure		
Kidney Disease			Other (specify)		
Liver Disease					
Lung Disease					

Do you have any allergies to: Penicillin Yes___ No___

Iodine Yes___ No___

Latex Yes___ No___

Seafood Yes___ No___

Dye Yes___ No___

Other Yes___ No___

If Yes, please list____

Do you drink alcohol? Yes___ No___ How many servings per week? _____________

Do you smoke? Yes___ No___ For how long?_______ How many a day?__________

Do you have AIDS or AIDS related illness? Yes____ No___

Do you have a “Do Not Resuscitate Order” or a “Living Will” in place? Yes___ No___

____ ____________________

Signature of Patient or Legal Guardian *Date*