Mercado Foot & Ankle Center Patient Medical History

Patient Last Name: _____ Patient First Name: _____
Date of Birth: _____ Chief Complaint: _____

List Medical Problems/Surgeries	Year

Current Medications	Dose	Reason

If you need more spaces than above, please continue on back.

Do you or your family have a history of: (check all that apply)	**Self**	**Family**
Cancer		
Coronary Artery Disease		
Diabetes—Type I Type II (circle one)		
Gastrointestinal Disease		
Hepatitis/HIV		
High Blood Pressure, Heart Disease, Arrhythmia		
Kidney Disease / Urinary		
Liver Disease		
Lung Disease		
Musculoskeletal, Bone, Joint, Pain, Swelling, Deformity		
Neurological Disease. Seizures, Memory, Dizziness, Headache, Behavioral Changes,Alzheimer's		
Skin Problems		
Stroke		
Other (specify)		

No Known Allergies	Yes	No		Yes	No
Penicillin			Dye		
Erythromycin (zpack/zithromax)			Seafood		
Sulfa			Eggs		
Codeine			Iodine		
Latex			Seasonal		
Tape/Adhesive			Other: (please list)		

Do you drink alcohol? Yes ____ No _____ How many servings per week? _____

Do you smoke? Yes____ No ____ For how long? _____ How many per day? _____

Do you have a 'Do Not Resuscitate Order' or a 'Living Will' in place? Yes ____ No ____

_____ _____
Signature of Patient or Legal Guardian Date