Ritchie Steed, DPM•Flatirons Foot & Ankle•2130 W. Mountain View Ave #203•Longmont•CO•80501

Date: ______________________

Name: ______________________________________________________

Reason for Today's Visit: __________________________________________________________________

**Allergies:**

__ Penicillin __ Aspirin __ Novocaine __ Band-Aid/Tape __ Codeine __ Iodine __ Shellfish

__ Latex __ Sulfa Drugs

Other Allergies: ________________________________________________________________________

**Current medications, pills, vitamins:** _______________________________________________________

_____________________________________________________________________________________

PLEASE CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOING CONDITIONS:

| | | | |
|---|---|---|---|
| __ Heart Trouble | __ Stroke | __ Psychiatric Care | __ Seizures |
| __ High Blood pressure | __ Kidney Problems | __ Diabetes | __ Depression |
| __ Heart Murmur | __ Lung Disease | __ Lack of Feeling | __ Back Pain |
| __ Heart Attack | __ Tuberculosis | __ Peripheral Neuropathy | __ Acid Reflux |
| __ Rheumatic Fever | __ Liver Disease | __ Stomach problems | __ Poor Healing |
| __ Artificial Heart Valve | __ Hepatitis | __ Foot Ulcers/Wounds | __ Gout |
| __ Heart Pacemaker | __ Circulation Problems | __ Thick Scars | __ Cancer |
| __ Peripheral Vascular Disease | __ Anemia | __ Bruise Easily | __ Arthritis |

*Other health issues: _____________________________________________________________________

**Past Surgeries:**_________________________________________________________________________

_____________________________________________________________________________________

Do you use tobacco in any form? __ Yes __ No Number of packs/day______ x _______ years

Do you drink alcoholic beverages? __ Yes __ No Number of drinks/week_____________

**WOMEN ONLY: Are you pregnant?** __ Yes __ No

Family History: ___ Diabetes ___ Heart Attack ___Heart disease ___High blood pressure

___High Cholesterol ___Circulation problems ___Foot problems

☐ To help Dr. Steed in my medical care, I give consent to the sharing of my medical information with my primary care doctor.

_____________________________________________

patient/guardian signature date