

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:

Immunizations up to date and Tetanus within the last 10 years? Yes No Not Sure

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

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> chills , nausea, night sweats | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lack of Feeling | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Poor Healing |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Foot Ulcers/Wounds | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Thick Scars | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Raynaud's disease | <input type="checkbox"/> Psoriasis | |

*Other health problems: _____

Past Surgeries: _____

Do you use tobacco in any form? Yes No Number of packs or cigars/day _____ x _____ years

If you have used tobacco in the last 24 months, have you received treatment or information to stop? Yes No

Do you drink alcoholic beverages? Yes No Number of drinks/week _____

Family History: Diabetes Heart Attack Heart disease High blood pressure High Cholesterol
 Circulation problems Foot problems

Shoe Size: _____

WOMEN ONLY: Are you pregnant? Yes No

**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