



Comprehensive Foot & Ankle Center

Dr. Loan K. Lam

8340 Collier Blvd Naples, FL

40 Heathwood Dr. 2nd Floor Suite E Marco Island, FL

Patient Name _____ Date _____

What is your main complaint today? _____

MEDICAL HISTORY:

List all medications you are currently taking:

Do you have or have you ever been treated for the following illnesses? None

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hearing Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Eye Disorders |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Depression/ Anxiety |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Nerve Damage | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Leg/ Foot Ulcers | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Other _____ | | | |

Do you have any vascular grafts or joint implants? _____

Do you have any allergies to medications? _____

Foods? _____ other? _____

Do you smoke now? Yes No If yes, how many packs per day? _____ For how long? _____

Did you ever smoke? Yes No When did you quit? _____ How long did you smoke? _____

Do you drink alcoholic beverages? None Rare Moderate Daily Quit

Indicate which of your immediate relatives have had any of the following diseases:

Cancer _____	Diabetes _____
Heart Trouble _____	High Blood Pressure _____
Kidney Disease _____	Mental/Emotional Disease _____
Stroke _____	Arthritis _____

Please give details of any:

Operations/Accidents	Approx. Date	Physician	Hospital

Patient Signature _____ Date _____