Northwest Surgery Center
Patient Medical History Sheet

Name: ______________________ Male / Female Age: ________
Date: ________________ Shoe size__________ Height_______ Weight:__________

Pharmacy Name & Phone #: ____________________ Family MD: ______________
What issue(s) are you having with your foot/feet? ______________________

Location: (Right or Left and area): ______________________

If both feet are affected, which side is worse? Right Left

When did it begin? ______________ Injury? __________ Date: ________

Describe Pain (sharp, dull, constant, etc.): ______________________

Anything aggravate the pain? ______________________
Anything alleviate the pain? ______________________

Before surgery is an option have you tried any conservitive methods below?

Home Treatment __________ Ice ______ Shoe Inserts ________ Wide Shoes
______Pads ______ Foot Soaks ______ Ibuprofen ________ Other
Professional treatment:

Any Foot Surgeries?____

Other Surgeries?____

Serious Illness?____

Does the dentist have any problems numbing your mouth?_________________________
Current Medications (Name & Dosage): ______________________

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Allergies and Reactions (Example: Codeine - rash)

Codeine	________	Penicillin	______	Latex	________	Keflex
Asprin	________	Sulfa	______	Lidocaine	________	**Other**
Local Anesthetics	________	Adhesive tape	______	Iodine	________	
Foods	________	Neosporin	______	**No Known Allergy**		

Medical Conditions - you or your family have or had in the past: MRSA/VRSA/C-diff__________ rashes

Alcoholism	________	Fibromyalgia	______	Kidney Disease	________	Stroke
Bleeding Disorder	________	Gout	______	LiverDS/Hepatitis	________	Tuberculosis
Blood Clots	________	High Cholesterol	______	Multiple Sclerosis	________	Varicose Veins
Diabetes	________	Heart Disease	______	Nerve Problems	________	Phlebitis
Seizures Epilepsy	________	High Blood Pressure	______	Poor Circulation	________	Arthritis Type

For each checked above explain: ______________________

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Patient signature: ______________________________

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