

MARYLAND PODIATRY CENTER

MEDICAL FORM

The following information is very important to your health. Please be complete.

Patient _____ Date ____/____/____

Primary Physician _____ ADDRESS _____ Telephone # _____

DATE LAST SEEN BY PRIMARY CARE PHYSICIAN (MM/YYYY): _____

AGE _____ Height _____ Weight _____ SHOE SIZE _____

CURRENT FOOT/ANKLE PROBLEM

In your own words, what foot/ankle brought you to our office today?

1. _____

2. _____

MEDICAL HISTORY

Please indicate whether you have a personal or family medical history of any of the following:

Problem	Yes, Personal History	Yes, Family History
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> ____ years	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, chronic	<input type="checkbox"/>	<input type="checkbox"/>
Heart (Surgery, Attack, Disease)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers, stomach, reflux (Circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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