

MARYLAND PODIATRY CENTER

MEDICATIONS

Please list all prescription and over-the-counter medications you are currently taking:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHARMACY: _____

ALLERGIES

_____ NKDA

Please check and describe any known allergies you may have and your reaction.

Adhesive tape	<input type="checkbox"/>	_____	Aspirin	<input type="checkbox"/>	_____
Codeine	<input type="checkbox"/>	_____	Eggs	<input type="checkbox"/>	_____
Iodine	<input type="checkbox"/>	_____	Local anesthetics	<input type="checkbox"/>	_____
Novocain	<input type="checkbox"/>	_____	Penicillin	<input type="checkbox"/>	_____
Latex	<input type="checkbox"/>	_____	Shellfish	<input type="checkbox"/>	_____
Sulfa	<input type="checkbox"/>	_____	Other: _____		
Other: _____			Other: _____		

List any Hospitalizations and Surgery you have had: _____

WOMEN:

Are you pregnant? YES _____ NO _____ Due Date _____

TOBACCO:

Current Y/N _____ Packs/day _____ Years Smoking _____

Previously Y/N _____ Packs/day _____ When did you Quit? _____

ALCOHOL:

Do you Drink Y/N _____ Drinks/day _____ /Week _____ When did you Quit _____

ILLEGAL DRUG USE:

Current Y/N-Name _____ IV Drugs Y/N _____ Date of Last Use _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge.

I give my permission for John Murphy, DPM to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

PATIENT OR GUARDIAN SIGNATURE

Date

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