Trinity Foot Center Lisa J. Brandy D.P.M. | 1801 N. Hampton Road Ste. 340 Desoto, TX 75115 * Phone: 972-293-9650 * Fax: 972-291-2533

MEDICAL HISTORY

PATIENT NAME: _____

State in your own words your medical reason(s) for coming into our office:

_____

_____

Is this visit related to an injury at work? (___) Yes (___) No

Shoe Size: _____ **Height:** _____ **Weight:** _____	**Are you a current smoker? Yes No**

FOR WOMEN ONLY: ARE YOU PREGNANT? _____IF SO HOW MANY MONTHS? _____

MEDICATIONS- Please list all medications that you currently use:

_____

_____

_____

ALLERGIES- Are you **allergic** to or have you ever reacted to any of the following?

Yes	No	Aspirin	Yes	No	Lidocaine (local anesthesia)
Yes	No	Band-aids/ tape	Yes	No	Sulfa drugs
Yes	No	Latex	Yes	No	Penicillin
Yes	No	Steroids	O**ther:** _____		

List Past Surgeries: _____

YOUR Past Medical History: Have **YOU** ever **HAD or HAVE** any of the following? **CHECK ALL THAT APPLY**

ENTM:	(__) Trouble Hearing	**GI:**	(__) Stomach Ulcers
	(__) Wears Hearing Aids		(__) GERD
Musculoskeletal:	(__) Arthritis		(__) Acid Reflux
	(__) Gout	**Endocrine:**	(__) Diabetes
Neurological:	(__) Cramping (legs or feet)		(__) Thyroid disorder
	(__) Numbness (legs or feet)		(__) Anemia
	(__) Tingling (legs or feet)	**Psychiatry:**	(__) Anxiety
	(__) Burning (legs or feet)		(__) Alzheimer's
	(__) Shooting Pain		(__) Dementia
CVS:	(__) Chest Pain		(__) Depression
	(__) Heart Disease	**Social:**	(__) Alcoholism
	(__) Shortness of Breath		(__) Drug Abuse
	(__) Ankle Swelling	**Immunology:**	(__) Cancer
	(__) High Blood Pressure		(__)HIV/AIDS
	(__) Kidney disease		
	(__) Stroke	**(___) NONE OF THE ABOVE**	

FAMILY Past Medical History: Circle **ALL** that apply

Father:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown
Mother:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown

X_____ _____

Patient's Signature or Parent/ Legal Guardian Date