

WILLIAMS FOOT CENTER

How did you learn of our practice? _____

MEDICAL HISTORY

MEDICAL REASON(S) FOR COMING TO OUR OFFICE: _____

PLEASE LIST ALL MEDICATIONS THAT YOU USE INCLUDING THE NAME AND DOSAGE AMOUNTS (IF KNOWN). IF YOU DO NOT KNOW THE NAME, TELL US WHAT YOU TAKE THEM FOR.

See attached list of medications (check only if list is provided)

MEDICATION ALLERGIES: _____

PHARMACY NAME: _____ **PHONE #:** _____

PLEASE CIRCLE BELOW IF YOU HAVE SIGNIFICANT HEALTH PROBLEMS IN ANY OF THE AREAS LISTED:

Yes	No	Heart/Describe	Yes	No	HIV/Hepatitis
Yes	No	High Blood Pressure	Yes	No	Arthritis/Type:
Yes	No	Peripheral Vascular Disease	Yes	No	Back Problems
Yes	No	Strokes	Yes	No	Cramps in feet/legs
Yes	No	Skin Problems/Describe:	Yes	No	Osteoporosis
Yes	No	Diabetes: ___ Insulin ___ Non-Insulin	Yes	No	Numbness in Feet/Legs
Yes	No	Thyroid Disorder	Yes	No	Neuropathy
Yes	No	Stomach Problems	Yes	No	Depression/Anxiety
Yes	No	Allergies	Yes	No	Psychiatric Problems
Yes	No	Liver Disease	Yes	No	Asthma
Yes	No	Kidney Disease/Stones	Yes	No	Pneumonia/Pleurisy/COPD
Yes	No	Eye Problems Describe:	Yes	No	Do you smoke?
Yes	No	Ear/Hearing Problems	Yes	No	Do you drink alcohol?

Other Illnesses/Surgeries? Please list (include dates): _____

I hereby give my consent to any medical treatment deemed necessary by Dr. Melvin Williams.

Signature

Date

