The Foot Doctor

Paul Baumgarten, DPM

9 W Sand Lake Road
Wynantskill, NY 12198
518-346-6000

Medical History Form

Please complete all sections. Type in the fields or print and write clearly.

Name: _____ Date of Birth: _____ Shoe Size: _____

MEDICAL HISTORY *(check all that apply)*

☐ Diabetes ◯ Type I ◯ Type II Doctor managing your diabetes: _____

Date last seen: _____ Most recent A1c: _____

☐ Alzheimer's	☐ Gout	☐ Lung Disease	☐ Total Joint Implant
☐ Anemia	☐ Heart Condition	☐ Osteoporosis	☐ Replacement Heart Valves
☐ Arthritis	☐ Hepatitis	☐ Poor Circulation	☐ Skin Condition
☐ Asthma	☐ High Blood Pressure	☐ Rheumatoid Arthritis	☐ No current problems
☐ Blood Disorder	☐ HIV	☐ Stomach Ulcer	☐ Other medical issues
☐ Cancer	☐ Kidney Disease	☐ Stroke	_____
☐ Glaucoma	☐ Liver Disease	☐ Thyroid	

☐ Foot surgery (describe): _____

CURRENT MEDICATIONS *(name, dose and how often)*

_____

ALLERGIES

☐ **NKDA (no known drug allergies)**

☐ Adhesives (tape/band-aids)	☐ Aspirin	☐ Betadine (iodine)	☐ Cephalosporins (Keflex)
☐ Cipro	☐ Codeine	☐ Erythromycin	☐ Ibuprofen
☐ Latex	☐ Penicillin	☐ Sulfa	☐ Tylenol

Other drug allergies: _____

SOCIAL HISTORY

Do you smoke? ◯ Never smoked ◯ Former smoker ◯ Currently smoking

If former, stopped smoking at age: _____ If current: ◯ Daily ◯ Occasionally Started at age: _____

FAMILY HISTORY *(check all that apply)*

Father	☐ Diabetes	☐ Heart Disease	☐ Cancer	☐ Stroke	☐ Blood Disorder	☐ Arthritis	☐ Unknown	
Mother	☐ Diabetes	☐ Heart Disease	☐ Cancer	☐ Stroke	☐ Blood Disorder	☐ Arthritis	☐ Unknown	

REVIEW OF SYSTEMS *(check any symptoms you currently have)*

Constitutional	☐ Anxiety ☐ Fatigue ☐ Fever ☐ Insomnia
Cardiovascular	☐ Leg pain when walking ☐ Leg swelling ☐ Cold hands/feet
Musculoskeletal	☐ Joint pain ☐ Joint stiffness ☐ Muscle weakness ☐ Muscle pain
Neurological	☐ Imbalance ☐ Numbness ☐ Tingling ☐ Tremors

Please read and sign:

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any updates to the information listed above.

_____ _____

Signature of Patient / Responsible Party (sign after printing) Date