804 Grandview Dr.
Ephrata, PA 17522
(717) 733-2251

Dr. Thomas M. Herrmann
Dr. Steven W. Kreamer
Dr. Peter J. Fodor
Dr. Melissa A. Cavallaro

Medical Information

Name:____ **Date:**__________________

Briefly describe your foot problem:____

____

Past foot problems:____

Past foot surgery:____

Medical History: Please circle any of the following you have or have had in the past

Heart trouble	High blood pressure	Epilepsy/Seizures
Poor circulation	Low blood pressure	Gout
Arthritis (what type?)	Heart murmur	Stroke
Kidney disease	Artificial heart valve	Diabetes
Lung disease	Artificial joint	Phlebitis/Blood clot
Cancer	Excessive bleeding	Thyroid disease
Asthma	Liver disease/Hepatitis	Tuberculosis
Stomach ulcers/Reflux	Blood transfusion	Rheumatic fever
AIDS/HIV	Alcohol abuse	Psychiatric treatment
Skin disease	Drug abuse	Depression
Anemia	Polio	Recent weight gain/loss

Height:__________________ **Weight:**________________ **Shoe Size:**_____________

Are you pregnant? Yes/No **How many weeks/months?**____ **Breast-feeding?** Yes/No

Surgical History: Please list any surgeries and the year you had them.

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____

Occupation:____

Do you or have you ever smoked? Yes/No **# packs per day? ______ How many years?____Quit?_______**

Have you ever been exposed to second hand smoke?_______

Do you drink alcohol? Yes/No **# of drinks per week? _______**

(2 SIDED, PLEASE COMPLETE OTHER SIDE OF FORM)

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Family History: List any medical problems that run in your family (heart trouble, arthritis, diabetes, etc…).

Mother: ______________________ Father: ______________________

Sister: ______________________ Brother: ______________________

Medications: Please list all of your current medications and dosages.

Name:	Dose:	How Often:

Allergies: Please circle if you are allergic to any of the following and describe reaction. **None:**______

Penicillin	Iodine (IV Dye or on skin)
Sulfa drugs	Adhesive tape
Other antibiotics	Anti-inflamatories
Aspirin	Latex
Lidocaine/Novacaine/Marcaine	Other:

Is there any other important information about you medical history not covered above?

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____

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The above information is correct to the best of my knowledge.

Patient signature:______________________________ **Date:**__________________