WELCOME TO OUR OFFICE

DR. RALPH J. WENTZ

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

MEDICAL HISTORY:

Name______________________Age:__________Weight:______Height:_______

Referring Physician:______________*REASON FOR TODAY'S VISIT:*___________

Please check if you have or have had any of the following:

___Diabetes (# of years ______)
___Numbness of Legs/Feet
___Poor Circulation
___Leg Cramping When Walking
___Heart Disease
___Hardening of the Arteries
___Raynaud's Disease
___Varicose Veins
___Phlebitis/Blood Clots
___Ankle Swelling
___Lupus/Scleroderma
___Anemia
___High Blood Pressure
___High Cholesterol
___Low Thyroid
___Stroke
___Heart trouble, Heart Attack, Murmur
___Kidney Trouble
___Liver Trouble/Hepatitis A-B-C
___Tuberculosis
___Stomach Ulcers
___Asthma/Emphysema/COPD
___Gout
___Broken Foot/Ankle Bones
___Blood Disease
___Cancer (type_________________)
___Epilepsy
___Osteoarthritis
___Osteopenia / Osteoporosis
___ Rheumatoid Arthritis
___ In a Risk Group of AIDS
___Have AIDS or are HIV Positive
___ Other ___________________

Previous Operations: List *ALL* operations you have had:

Operation: Date:

____

____

____

____

Current Medications:

List any medicines, steroids, inhalers, or drugs (including aspirin) you are taking now:

Medication: Dose: When:

____

____

____

____

Known drug allergies: Are you allergic to any medicines (including iodine, tape or anesthesia)?
Yes_________No_______

Allergy: Type of Reaction:

____

____

____

FAMILY HISTORY: Unknown Adopted ___

	Alive (Age)	Death (Age)	Cause	Serious Problem
Mother				
Father				
Brothers				
Sisters				
Children				

SOCIAL HISTORY:

Who lives with you?____

Your type of work____

Are you retired?____

HABITS:

Smoking history?___Yes_____No How many packs per day?_______How many years?_____

If stopped smoking, when?_____________How long did you smoke?_____________________

Alcoholic beverage use:__Yes__No How many drinks per day?__________________

Caffeine use: Do you use caffeine (coffee, tea, soda)?____Yes____No

Exercise: (Type and frequency)____

Have you had any problems with: General Anesthesia? ____Yes ____No

Excessive bleeding during surgery? ____Yes____No

Slow wound healing after surgery? _____Yes____No