

Name _____ Date _____

PLEASE CHECK ALL THE CONDITIONS WHICH PERTAIN TO YOUR MEDICAL HISTORY

- | | |
|--|---|
| _____ Diabetes | _____ Anemia/Blood Disease or Infection |
| _____ Hypertension (High Blood Pressure) | _____ Kidney/Liver Disease |
| _____ Heart Disease | _____ Gastric/Stomach Ulcer |
| _____ Mitral Valve Prolapse/Heart Murmur | _____ Gastritis/Hiatal Hernia |
| _____ Emphysema/Lung Disease/Pneumonia | _____ Seizure Disorders |
| _____ Asthma | _____ Wound Care Problems |
| _____ Painful Arthritis | _____ (Other) _____ |

CURRENT PRESCRIPTION MEDICATIONS (and OTC Meds)

- 1) _____ 3) _____ 3) _____
2) _____ 4) _____ 6) _____

ALLERGIES

- 1) _____ 2) _____ 3) _____ 4) _____

Please describe your "allergic reaction" : _____

HOSPITALIZATIONS and SURGERIES (or Minor Foot Surgery) WITHIN THE PAST 5 YEARS

_____ Date _____
_____ Date _____
_____ Date _____

How did you find out about Drs. Caputo/or Associates? Please check all that apply!

- _____ Family Physician _____ Other Doctor/Nurse/Therapist (name) _____
_____ Insurance List _____ Friend/Relative (name) _____
_____ Hospital Referral _____ Newspaper _____ Yellow pages _____ Other _____

Have you or has anyone in your family been treated in our office before? YES / NO

If yes, who? _____