THOMAS RAMBACHER, DPM

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	YES	NO		YES	NO		Yes	NO
Aids/HIV	_____	_____	Epilepsy	_____	_____	Radiation Treatment	_____	_____
Allergies to Anesthetics	_____	_____	Eye Problems	_____	_____	Rash	_____	_____
Allergies to Medicine	_____	_____	Fainting	_____	_____	Respiratory Disease	_____	_____
Anemia	_____	_____	Foot or Leg Cramps	_____	_____	Rheumatic Fever	_____	_____
Angina	_____	_____	Gout	_____	_____	Shortness of Breath	_____	_____
Arthritis	_____	_____	Headaches	_____	_____	Sinus Problems	_____	_____
Artificial Heart Valves	_____	_____	Heart Disease	_____	_____	Special Diet	_____	_____
Asthma	_____	_____	Hemophilia	_____	_____	Stroke	_____	_____
Back Problems	_____	_____	Hepatitis or Jaundice	_____	_____	Swelling in Ankles, Feet	_____	_____
Bleeding disorders	_____	_____	High Blood Pressure	_____	_____	Swollen Neck Glands	_____	_____
Cancer	_____	_____	Kidney Problems	_____	_____	Tired Feet	_____	_____
Chronic Diarrhea	_____	_____	Liver Disease	_____	_____	Tuberculosis	_____	_____
Chest Pain	_____	_____	Low Blood Pressure	_____	_____	Ulcers	_____	_____
Circulatory Problems	_____	_____	Nervous Problems	_____	_____	Varicose Veins	_____	_____
Diabetes	_____	_____	Phlebitis	_____	_____	Venereal Disease	_____	_____
Ear Problems	_____	_____	Psychiatric Care	_____	_____	Weight Loss, unexplained	_____	_____

Surgeries you have had: _____

_____

Hospitalizations other than for the surgeries listed: _____

_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? _____Yes _____ No

If yes, please explain: _____

_____

MEDICATIONS

Include prescriptions, over-the counter medications and vitamins: _____

_____

_____

Pharmacy Name: _____ Pharmacy Phone: _____

Do you take oral contraceptives? _____ Yes _____ No

ALLERGIES

____ Adhesive/Tape
____ Anticoagulant Therapy
____ Aspirin
____ Codeine
____ Demerol
____ Iodine
____ Local
____ Novocain
____ Penicillin
____ Seafood
____ Sulfa

Other:_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my feet.

Patients Signature: _____ Date: _____