Brent S. Wood, DPM

Foot and Ankle Specialist

Medical History

Please place a check on "Yes" or "No" to indicated if you have/had the following medical conditions:

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Epilepsy			Rash		
Allergies to Anesthetics			Fainting			Respiratory Disease		
Anemia			Foot/Leg Cramps			Shortness of Breath		
Arthritis			Gout			Sinus Problems		
Artificial Heart Valves			Headaches			Special Diet		
or Joints			Heart Disease			Stroke		
Asthma			Hemophilia			Swelling in Ankles/Feet		
Back Problems			Hepatitis/Jaundice			Swollen Neck Glands		
Bleeding Disorders			High Blood Pressure			Tired Feet		
or Blood Clots			Kidney Problems			Tuberculosis		
Cancer			Liver Disease			Ulcers		
Chemical Dependency			Low Blood Pressure			Varicose Veins		
Chronic Diarrhea			Nervous Problems			Venereal Disease		
Circulatory Problems			Phlebitis			Vision Problems		
Diabetes			Psychiatric Care			Weight Loss		
Hearing Problems			Radiation			(unexplained)		

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: _____

_____

Surgery History: _____

_____

Hospitalization History (other than surgeries): _____

_____

Allergies:

____	Adhesive Tape	____	Anticoagulant Products	____	Aspirin	____	Codeine
____	Demerol	____	Iodine	____	Latex	____	Local Anesthetic
____	Novocaine	____	Penicillin	____	Seafoods	____	Sulfa
____	Other:	_____					

Medications: _____

_____