Dr. Aamir Ahmed DPM
Dr. Venkatramesh Medapati DPM
2001 N McArthur Blvd Suite 300 Irving TX 75061
P: 972-254-0680
F: 972-254-0683

MEDICAL IFORMATION

What is your foot/ankle problem?_____

_____

Duration? _____Days:_____Weeks:_____Months:_____Years:_____ R or L Foot?_____

Any Prior Treatment? _____By Whom?_____

Primary Physician: _____ Date of Last Exam: _____

Former Podiatrist: _____

Have you had any problems whit your feet or ankles? _____

Have you had any operations (surgery) whit your feet or ankles? _____

GENERAL HEALTH INFORMATION:

Weight: _____ Height: _____ Current Shoe Size/Width _____ Type of shoe normally worn: _____

Do you have Diabetes? ☐ Yes ☐ No. If yes, do you take Insulin? ☐ Yes: ☐ No of Years _____

Have you had any serious illness or have you had any surgery? ☐ Yes ☐ No If yes, what: _____

_____

Are you currently under the care of any other physician? ☐ Yes ☐ No If yes for what problem(s)? _____

_____

Do you or did you smoke, dip or chew tobacco? ☐ Yes ☐ No If yes, number of packs/ cigars per day: _____ number of years: _____ if you quit using tobacco, how long ago? _____

Do you drink beer, wine or alcohol? ☐ Yes ☐ No If yes, ☐ occasional ☐ moderate ☐ heavy

Do you drink beverages with caffeine? ☐ Yes ☐ No If yes, ☐ coffee ☐ tea ☐ soft drinks

At your job do you ☐ sit most of the time ☐ stand most of the time ☐ stand and walk

Does your employer require you to wear certain shoes at work? ☐ Yes ☐ No If yes, are the shoes

☐ Boots with steel toes ☐ dress [men] fashion shoes [women] high heels

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Please list all medications you take

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____
17 _____
18 _____
19 _____
20 _____

Pharmacy: _____
Address: _____ Phone Number: _____

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Please check if you have ALLERGIES (REACTIONS) to:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine (Betadine or dye)
- ☐ Keflex
- ☐ Tetaccycline
- ☐ Davon/Darvocet
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Anti-inflammatory (Naprosyn, Advil, Motrin, Aleve, et)
- ☐ Codeine
- ☐ Morphine or Demerol
- ☐ Local anesthesia
- ☐ Adhesive tape: Band-aids
- ☐ Other(s)

_____

_____

_____

Do you have any artificial joint(s) or heart valve: ☐ Yes ☐ No If yes, where: _____

Please check if you have a problem with any of the following:

- ☐ Frequent fainting
- ☐ Dizziness
- ☐ Migraine(s)
- ☐ Weight loss
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Teeth or gum problems
- ☐ Blood transfusion(s)
- ☐ Heart attack
- ☐ Mitral valve problems
- ☐ Obstructive pulmonary disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ AIDS/ HIV/ ARC
- ☐ Getting up to urinate after going to bed
- ☐ Urinary incontinence
- ☐ Hemorrhoids
- ☐ Prostate problems
- ☐ Yeast infections
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Stiffness
- ☐ Chronic low back pain
- ☐ Thick scar or keloid formation
- ☐ Skin rash or keloid
- ☐ Skin Cancer
- ☐ Tattoo(s)
- ☐ Tingling in arms, hands, legs or feet
- ☐ Memory loss
- ☐ Depression
- ☐ Panic attacks
- ☐ Obsessive-compulsive disorder
- ☐ Menopause
- ☐ Sickle cell disease or trait
- ☐ Anemia
- ☐ Gout
- ☐ Frequent infections
- ☐ Asthma
- ☐ Other Cancer(s)

_____

IRVING FOOT AND ANKLE

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☐ Rheumatic Fever ☐ Numbness or burning in arms, hands, or feet

☐ Gastric reflux

FAMILY HISTORY:

Mother ☐ Living ☐ Deceased Cause of death: _____

Father ☐ Living ☐ Deceased Cause of death: _____

Brother ☐ Living ☐ Deceased Cause of death: _____

Sister ☐ Living ☐ Deceased Cause of death: _____

Please check if there is a family member (blood relative) history of:

☐ Arthritis ☐ Sickle Cell ☐ Flat Feet ☐ Neurologic disorders

☐ Heart Disease ☐ Diabetes ☐ Bunions

☐ Bleeding disorders ☐ Gout ☐ Hammertoes

_____ _____

Signature Date