Allegiance Family Foot Care

Robson F. Araujo, DPM, FACFAS
601 A Corley Avenue • Boaz, AL 35957
Phone: 256-840-4810 • Fax 256-840-4815

Medical History

Name: _____ **Date**: _____

Do you have or ever had any of the following?

Acid Reflux	☐	Colitis	☐	Heart Attack	☐	Neuropathy	☐
Anemia	☐	Congestive Heart Failure	☐	Hepatitis	☐	Over Active Thyroid	☐
Angina	☐	Coronary Artery Disease	☐	High Blood Pressure	☐	Peripheral Vascular Disease	☐
Arthritis	☐	Dementia	☐	High Cholesterol	☐	Pneumonia	☐
Asthma	☐	Diabetes	☐	HIV/AIDS	☐	Stroke	☐
Bronchitis	☐	DVT/Blood Clot	☐	Kidney Failure	☐	Transient Ischemic Attack	☐
Cancer	☐	GERD	☐	Kidney Stones	☐	Ulcer	☐
Cirrhosis	☐	Gout	☐	Low Blood Pressure	☐	Under Active Thyroid	☐

Please list the following:

Medical Conditions: _____

Current Medications: _____

_____

Surgeries: _____

Any problems with anesthesia? If yes, please explain _____

List any allergies: _____

_____

SOCIAL HISTORY: Married ☐ Single☐ Divorced ☐ Widowed ☐ Separated ☐

Occupation: _____ Do you use tobacco? Yes ☐ No ☐ Do you use alcohol? Yes ☐ No ☐

Exercise: Walk ☐ Run☐ Cycle ☐ Weights☐ Swim ☐ Yoga ☐ Aerobics ☐

FAMILY HISTORY (parents, grandparents, siblings): Diabetes ☐ Poor Circulation ☐ Cancer ☐

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Patient Signature _____ Date _____ Physician Signature: _____ Date _____