

DAVID W. MANSKY, D.P.M.
PATIENT'S HISTORY
(Please print and complete as fully as possible)

Date _____

Patient Name _____ Spouse _____

Guardian's name if patient is a minor _____

Address if different than patients _____

What is your foot problem? _____

When did this start? _____

Any previous treatment? _____

What type of work do you do? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS THE BEST YOU CAN

Your: Height _____ Weight: _____ Shoe Size: _____

Physicians name, address, and phone number:

What medications are you presently taking:

Are you pregnant? () Yes () No

Do you smoke? () Yes () No If yes, how much? _____ How long? _____

How long did you smoke? _____

Do you drink alcohol? _____

Do you use illegal drugs such as marijuana, cocaine? () Yes () No

If yes please explain:

CONTINUE ON OTHER SIDE

() I'M NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE
I'M ALLERGIC TO (PLEASE CHECK ALL THAT APPLY)

_____ Aspirin	_____ Lidocaine (local)
_____ Codeine	_____ Iodine
_____ Penicillin	_____ Sulfa
_____ Adhesive/ Tape	_____ Sutures
_____ Latex	_____ Other

Explain the type of "Allergic" reaction you have had to any of the above:

I HAVE HAD OR HAVE THE FOLLOWING:

(PLEASE CIRCLE ALL THAT APPLIES)

Diabetes	Bleeding Tendencies	Asthma
Heart Trouble	Liver Problems	Stroke
Low Back Pain	Kidney Problems	Gout
Blood Clots	High Blood Pressure	HIV-AIDS
Heart Attack	Poor Circulation	Cancer
Rheumatic Fever	Stomach Ulcers	Arthritis
Lung Problems	Hepatitis	Other: _____

Please list all of the hospitalizations and surgeries you have had:

Are you taking a blood thinner? _____ yes _____ no

Do you have any Prosthetic Joints/Implants/Heart Valves: _____

Do you require antibiotic before going to the dentist or having any procedures done?

() Yes () No

Signature of patient/guardian/parent: _____

Date: _____

Person Giving Information _____