



DR. DAVID C. STEGE

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY

Patient Medical History

Last Name _____ First Name _____ Middle I ____ Todays Date _____

Date of Birth _____ Age _____ Height _ _____ Weight _____

Are you in good general health? Yes No Have you been under a doctors care in the past two years? Yes No

Females: Are you pregnant? Yes No Are you allergic to any medication or substance? Yes No

Allergies: _____

PAST MEDICAL HISTORY: (Please check any of the following you have experienced.)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack/Angina | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Anxiety Problem | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> HIV | <input type="checkbox"/> Psychological/Psychiatric Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bipolar Disease | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Colon Polyp | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |

Other Medical Problems: _____

Please list ALL medication or drugs you are presently taking: _____

Preferred Pharmacy: _____ City _____ Street _____ eRx

SOCIAL HISTORY:

Do you smoke now? Yes No _____ packs/day Smoke in the past? Yes No _____ packs/day _____ # years

Do you drink alcoholic beverages? None Quit Rarely Moderately Daily

Do you have a history of drug or alcohol abuse? Yes No

List any sports or activities _____

How much time are you on your feet at work? 10% or less 20% 40% 60% 80% 100%

Patient Signature