FAMILY FOOT & ANKLE PHYSICIANS, PLLC
J. SCOTT STANCIL, DPM AMY M. PITZER, DPM RICK C. CHEN, DPM BRIAN L. JONES, DPM
1432 East Fire Tower Road Greenville, North Carolina 27858 (252) 439-1150

MEDICAL HISTORY

Full Name: ____ Today's Date: ____________________

Date of Birth: ________________

Primary Care Physician's Name: ____
Phone Number: ________________
Date of last visit: _______________

Are you currently under your doctor's care? Yes No
If so, for what reason? ____

What is your Height? ________________Weight? _______________ Shoe size? ________________________

Have you had previous treatment by a podiatrist? Yes No When? ___________________________
For what reason? ____

What is the reason for your visit today?
____
____

Do you now have or have you ever had any of the following? Please check all that apply.

O Anemia
O Arthritis
O Asthma
O Bleeding problems
O Blood disease
O Breathing/Lung problems
O Cancer
O Diabetes
O Epilepsy
O Fainting spells
O Glaucoma
O Heart trouble
O High blood pressure
O High Cholesterol
O Kidney disease
O Leg cramps
O Liver disease
O Muscle disease
O Nervousness
O Pacemaker
O Polio
O Rheumatic/Scarlet fever
O Skin rashes
O Stomach/intestinal ulcers
O Stroke
O Thyroid disease
O Tuberculosis
O Varicose veins
O Other (please specify)
____

Does any of your immediate family (father, mother, sister, brother, grandparents) have any of the above conditions? Please list: -
____
____

What pharmacy do you prefer? Please list location and/or phone number of pharmacy.
____

Please list *all* medications you are taking including aspirin and birth control:

____

____

____

ALLERGIES Select all known allergies below ☐ No known allergies

☐ Novocain ☐ Codeine ☐ Adhesive tape ☐ Sulfa ☐ Foods

☐ Penicillin ☐ Iodine ☐ Other ____

Do you smoke? YES NO If Yes, how many packs per day? ______

Do you use alcohol? YES NO If yes, how much do you drink per week? ______

Do you use street drugs? YES NO If yes, please list: __________________________

Have you been in contact with the AIDS virus? YES NO

Have you had a Flu Vaccine in the last 12 months? YES NO

Have you had the COVID Vaccine in the last 12 months? YES NO

Have you had a Pneumonia Vaccine in the last 5 years? YES NO

Please list and date any surgeries you've had since childhood.

____

____

____

Please list and date any injuries you've had since childhood.

____

____

____

Is there anything else we should know about your general health?

____

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I certify that the above information is true and correct to the best of my knowledge. I hereby give Dr. Stancil, Dr. Pitzer, Dr. Chen, and/or Dr. Jones permission to administer and perform such procedures as may be deemed necessary to diagnose and/or treat my feet/ankles. Also, I understand that photographs and/or X-rays may be taken of my feet/ankles and are a part of my permanent medical record.

____ __________

Signature **Date**