Dr. Timothy L Gardner DPM PC
Family Foot and Ankle Clinic

Patient Medical Information

Describe you Foot/Ankle problem today:

Was this a result of an injury? YES NO

Have you had other issues with your feet or ankles in the past? YES NO

If yes, please list any past Foot/Ankle Surgical Procedures with approximate dates.

Shoe Size: _____ Current Weight:_____ Current Height: _____

List any medication allergies that you are aware of:

Have you had problems with local anestetics? YES NO

Are you allergic to LATEX? YES NO

Do you have diabetes? If yes, what year were you diagnosed? _____ YES NO

What was your latest blood sugar or A1C reading? | |

Have you ever been diagnosed with MRSA? YES NO

Circle any of the following that you are being treated for or have been treated for in the past:

Heart Disease Hormones Intestines Asthma Tuberculosis Liver Weight Gain/Loss

Kidney Disease High Blood Pressure Skin Conditions Neurological Cancer

Frequent Infections Rheumatic Fever MRSA Circulation Anemia Stroke Ulcers

Respiratory COVID-19 Gout Bladder Arthritis OTHER _____

Please list major surgical procedures that you have had and the approximate year it was performed:

Do you have any artificial joints or implants? If so, what & when? YES NO

Do you have a heart valve implant? If so, when was it placed? _____ YES NO

Do you smoke? If so, approximately how many/day? _____ YES NO

Did you previously smoke? # of Years? _____ YES NO

Alcohol Consumption? 1-2/week 1-2/day More than 2/day YES NO

Activity Level: Sedintary Light Moderate Very Athlete

Family History

Please circle if a close blood relative has had any of the following:

Heart Disease Bleeding Disorder Bunions Arthritis Stroke Hammertoes

Neurological Disorder Stroke Circulatory Problems Flat Feet

Medications

Please list all medications that you take on a daily basis (Prescription and Over the Counter)

*Continue on Back if needed