ATLANTA FOOT AND ANKLE CENTER

PERRY H. JULIEN, DPM
CHARLES F. PEEBLES, DPM

NAME _____ AGE _____ DATE _____
PLACE OF BIRTH: _____ DATE OF BIRTH _____
SHOE SIZE: _____

LOWER EXTREMITY PROBLEM: _____
_____

DATE OF ONSET: _____ PREVIOUS TREATMENT: _____

PERSONAL HEALTH: Have you ever had any of the following (Please Mark):

_____ Alcoholism
_____ Allergies
_____ Arthritis
_____ Asthma
_____ Bone Disease
_____ Blood Disease
_____ Bronchitis
_____ Bleeding Tendencies
_____ Cancer - Tumors
_____ Congenital Deformities
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Gout
_____ Heart Disease
_____ Hepatitis
_____ High/Low Blood Pressure
_____ HIV
_____ Kidney Problems
_____ Liver Problems
_____ Neuritis
_____ Polio
_____ Psoriasis
_____ Psychiatric Illness
_____ Rheumatic Fever
_____ Stomach Problems
_____ Stroke
_____ Ulcers (Stomach)

Other _____

MEDICATIONS: (Please list ALL including non-prescription medications)

NAME	REASON FOR TAKING	DATE STARTED

ALLERGIES:

_____ PENICILLIN _____ ASPIRIN
_____ SULFA _____ IODINE
_____ CODEINE _____ DEMEROL
_____ ADHESIVE TAPE
_____ OTHER _____

DO YOU SMOKE?
No____ Yes _____Packs
Number of Years _____

DO YOU DRINK ALCOHOL?
Yes _____ No _____
_____ Drinks/Week

FAMILY MEDICAL PROBLEMS _____
_____

SURGICAL/HOSPITALIZATION HISTORY:

Type of Surgery/Reason for Hospitalization	Hospital	Date

PHYSICAL ACTIVITY

Walking
Jogging/Running
Cycling/Spinning
Aerobic Dance/Step
Tennis/Racquetball
Weight Training
Other _____

Frequency _____ NO REGULAR EXERCISE

PLEASE INDICATE IF THERE IS ANY ADDITIONAL INFORMATION YOU WOULD LIKE DR. JULIEN OR DR. PEEBLES TO KNOW: _____