New Tampa Foot & Ankle

Dr. Stephen F. Levin, DPM, Dr. Martin Port, MS, DPM & Dr. Brendan Barrett, DPM
26827 Foggy Creek Road, Suite 104, Wesley Chapel, FL 33544
3704 Euclid Avenue, Tampa, FL 33629
Phone: 813-973-3535 | Fax: 813-907-2963

South Tampa Foot & Ankle

Patient Name: _____ Date of Birth: _____ Date: _____
Primary Care Doctor: _____ Last visit: _____
Former Podiatrist Name: _____ Last visit: _____
Other Provider: _____ Last visit: _____

MEDICAL HISTORY

□ Male □ Female Height_____ Weight_____ Shoe Size_____

1. What is your primary reason for visiting our offices: _____
2. How is your general health? □ Good □ Fair □ Poor
3. Are you now, or within the past two years, under a physician's care? □ Yes □ No
If yes, what are you being treated for: _____
4. Do you take prescribed and/or over the counter medicine? □ Yes □ No
If yes, what medications are you taking? (Please list or provide a copy of list): _____
5. Are you allergic to any medicines, adhesive tape, latex or penicillin? □ Yes □ No
(Please list ALL allergies you have): _____

6. Do you have now, or have you ever had any of the following:

□ Anemia
□ Arthritis
□ Asthma
□ Blood Diseases
□ Broken Bones in Legs or feet
□ Cancer – Type: _____
□ High Cholesterol/Triglycerides
□ Circulation Disease/Problems
□ Cramps in Feet or Legs
□ Diabetes
□ Digestive Problems
□ Epilepsy
□ Eye Problems
□ Gout
□ Heart Problems
□ Hepatitis
□ High Blood Pressure
□ HIV / AIDS
□ Kidney Problems
□ Liver Problems
□ Melanoma
□ Numbness of Feet / Legs
□ Phlebitis
□ Prolonged Bleeding
□ Raynaud's Disease
□ Rheumatic Fever
□ Skin Cancer
□ Stomach Ulcers
□ Thyroid Condition
□ Tuberculosis

7. If Diabetic, please check applicable: □Taking insulin □Taking medication(s) □Diet controlled
How long have you been diabetic?_____ What is your average blood glucose range? _____
When was your last A1C level drawn? _____ What was your last A1C number/value? _____

8. Is there a family history of diabetes? □ Yes □ No Which family member(s)? _____
Insulin Dependent? □ Yes □ No

9. Do you smoke? □ Yes □ No
If yes, how many packs per day? _____ How long have you smoked? _____
If you have quit smoking, how long ago did you stop? _____
How many packs per day did you smoke? _____ How long did you smoke? _____

10. Do you drink alcohol (please circle one): □ Never □ Rarely □ Occasionally □ Moderately □ Daily

11. Have you had any surgeries? □ Yes □ No [If yes, Please list below:]

Date	**Surgical Procedure**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____