

DR. JOHN G. MCMAHON, JR – ADULT & CHILD FOOT & ANKLE CARE
Medical Information Form

Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

What name would you like to be called _____

Height _____ Ft _____ In _____ Weight _____ Lbs _____ Shoe Size _____ Width _____

Reason For Your Visit _____ Duration of Problem _____

Primary Care Dr. _____ Ph# _____ Date Last Seen _____

1. If You Have Been Under a Physician's Care In The Last Two Years Please

Explain: _____

2. Do You Have a History of:

Diabetes: _____ Cancer: _____ Hypertension: _____ Gout: _____

Heart Trouble: _____ Allergy: _____ Arthritis: _____

Liver Problems: _____ Circulatory problems: _____ Kidney problems: _____

3. Have You Ever Had or Been Treated For:

Heart Condition _____ Asthma _____ Stroke _____

Epilepsy/Seizures _____ Liver _____ Kidneys _____

Rheumatic Fever _____ Thyroid disease _____ Pacemaker _____

Other _____

4. Have You Had Any Serious Illnesses Or Surgeries? Y or N Explain: _____

5. Are You Subject To Prolonged Bleeding? Y or N Explain: _____

6. Have You Ever Experienced A Side Effect From Any Medication? Y or N

Novocain Penicillin Antibiotics _____ Other _____

What type of reaction did you have? _____

7. (Women) Are you pregnant? Y or N

8. Do you smoke? Y or N How many cigarettes or packs per day? _____

9. Do you drink alcohol? Y or N __ Socially __ Daily, How many per day? _____

10 . Medications You Are Presently Taking? Include over the counter, prescription, and vitamins

Pharmacy Name: _____ Phone: _____

**I HEARBY GIVE PERMISSION TO DR. JOHN G. McMAHON, JR. D.P.M. TO ADMINISTER TREATMENT
AND TO PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE
DIAGNOSIS AND TREATMENT OF MY FOOT AND/OR ANKLE CONDITION.**

SIGNATURE _____ **DATE** _____

