MELECA FOOT AND ANKLE
DR. SALVATORE MELECA, DPM

# Patient Health Information

Given Name: _____ Surname: _____

Current Illness/Chief Complaint

Onset Date: _____ Location: _____ Pain Level(1-10): _____

Allergies: _____ Phone(___) _____

**Medical History (Check All that Apply)**

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Back Pain
- ☐ Bladder Infections
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Bronchitis/Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Neuropathy
- ☐ Open Sores
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Ulcers

**Family Medical History**

- ☐ Asthma
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Back Pain
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease/Failure
- ☐ High Blood Pressure
- ☐ Mental illness
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other: _____

**Current Medications**

Medication: _____ Strength: _____ Dose: _____ per day

Medication: _____ Strength: _____ Dose: _____ per day

Medication: _____ Strength: _____ Dose: _____ per day

**Previous Surgeries**

Type of Surgery _____ Surgery Date: _____

Type of Surgery _____ Surgery Date: _____

**Do you use tobacco?** ☐ Non-Smoker ☐ Former Smoker ☐ Current Smoker ___ Packs per day
**Do you use Alcohol?** ☐ Daily ☐ Frequently ☐ Occasionally

432 Paseo Reyes Drive
St. Augustine, FL 32095
(904) 460-1120

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I, (please print name)_____hereby certify that the aforementioned information disclosed in my patient health information is true, complete and thorough to the best of my capabilities and that I am not under the influence, by any means, of a substance that would impair my ability to relay such information. I acknowledge that any untruthful or incomplete information in the above categories of my patient history can be either misleading to my medical provider, affect my medical treatment and even be detrimental to my own health. Lastly, I also understand that the information disclosed in my history is confidential and will not be used by any means for any other purpose but to solely aid in my medical provider's understanding of my medical condition(s) and for my treatment plan by Meleca Foot and Ankle and its providers. I understand that all information in this history will be kept confidential according to HIPAA regulations and standards.

Signature:_____

Date:_____

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