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HEALTH HISTORY

Patient Name: _____ **Today's Date:** _____

To help us meet your healthcare needs, please fill out this form completely with black ink. This is a confidential record of your medical history and will be kept in this office.

Basic Information:

Birth date: _____

Occupation: _____

Marital Status: _____

Exercise: _____ Daily _____ Rarely
_____ Weekly _____ Never

Please list all **medications** (include nonprescription and dosages that you are currently taking. _____ None

Smoking Status: _____ Never smoked _____ Current every day _____ Current some days
_____ Chew tobacco _____ Former smoker _____ Unknown

Alcohol Use (type and amount per week): _____

Please list all **ALLERGIES** (foods, drugs, environmental):

When was your last Physical Exam?: _____

Name of Family Doctor: _____



PLEASE LIST THE REASON FOR YOUR VISIT TO DR. MARASCO TODAY:

