

PATIENT MEDICAL HISTORY

Patient's Name: _____ Age: _____

Height: _____ Weight: _____ Shoe Size: _____

What condition are you being seen for today? _____

Where is it? _____

How long have you had it? _____

What started it or makes it worse? _____

What makes it better? _____

What treatment have you had? _____

Have you ever been treated by another podiatrist? _____

If so, who, for what condition? _____

MEDICAL HISTORY: Do **you** have a history of any of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Paralysis | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Phlebitis/blood clots | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Keloids |
| <input type="checkbox"/> Arthritis - <input type="checkbox"/> rheumatoid, <input type="checkbox"/> osteoarthritis -location _____ | | | |

Have **you** had any of the following conditions **recently**?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Poor healing | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Immune system problems | <input type="checkbox"/> Problems hearing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Large weight change | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Excessive coughing |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Frequent thirst | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent anxiety | <input type="checkbox"/> Psychiatric history |
| <input type="checkbox"/> Neurologic problems | <input type="checkbox"/> Numbness | <input type="checkbox"/> Leg cramps | |

List all previous significant **injuries** and dates(broken bones, sprains, etc.) _____

Other problems or conditions not listed above: _____

Family doctor and other doctors you are currently seeing: _____

SURGERY

List all previous surgeries and dates: _____

MEDICATIONS: Please list ALL

<u>Medication</u>	<u>How Often Taken</u>	<u>Strength</u>	<u>Why Taking</u>

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Other antibiotics _____
<input type="checkbox"/> Novacaine	<input type="checkbox"/> Iodine	<input type="checkbox"/> Codeine	
<input type="checkbox"/> Tape/Band-Aids	<input type="checkbox"/> Metal	<input type="checkbox"/> Other (food, fabric, etc.) _____	

SOCIAL HISTORY (please circle)

Exercise, Sports, or Recreational Activities _____

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Occasional	Moderate	Daily	
Smoking:	No	Yes, how much? _____			
Recreational/Street Drug Use:	Never	Rare	Daily		

FAMILY HISTORY

Please list diseases common to your family including heart disease, diabetes, rheumatoid diseases, arthritis, and genetic problems.

Grandparents: _____

Father: _____

Mother: _____

Siblings: _____

COMMENTS: _____
