

PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What condition(s) are you being seen for today? \_\_\_\_\_

MEDICAL HISTORY: Have you had, or do you currently have any of the following? Please check **all** that apply.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Circulatory problems        | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Cancer _____           |
| <input type="checkbox"/> Hepatitis/Liver problems     | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Paralysis           | <input type="checkbox"/> Currently pregnant     |
| <input type="checkbox"/> Kidney Disease/Renal Failure | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Neuritis/neuralgia  | <input type="checkbox"/> Large weight change    |
| <input type="checkbox"/> Hyperthyroid                 | <input type="checkbox"/> Heart Disease/ Heart attack | <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Weakness/fatigue       |
| <input type="checkbox"/> Hypothyroid                  | <input type="checkbox"/> Bleeding Tendency           | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Stomach Ulcers         |
| <input type="checkbox"/> Swollen glands               | <input type="checkbox"/> Blood Transfusion           | <input type="checkbox"/> Psychiatric history | <input type="checkbox"/> Digestive problems     |
| <input type="checkbox"/> Gout                         | <input type="checkbox"/> Stroke(CVA)                 | <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> Frequent sore throat   |
| <input type="checkbox"/> Rheumatic fever              | <input type="checkbox"/> Swelling of feet or ankles  | <input type="checkbox"/> Depression          | <input type="checkbox"/> Frequent thirst        |
| <input type="checkbox"/> Bone/joint disease           | <input type="checkbox"/> Slow to heal                | <input type="checkbox"/> Frequent anxiety    | <input type="checkbox"/> Frequent headaches     |
| <input type="checkbox"/> Rheumatoid Arthritis         | <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> COPD                | <input type="checkbox"/> Frequent urination     |
| <input type="checkbox"/> Osteoarthritis/DJD           | <input type="checkbox"/> Leg cramps                  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin rashes/conditions |
| <input type="checkbox"/> Swelling of Joints           | <input type="checkbox"/> Varicose veins              | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Chicken Pox            |
| <input type="checkbox"/> Back pain                    | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Immune system problems |
|   |  | <input type="checkbox"/> Excessive coughing  | <input type="checkbox"/> HIV/AIDS               |

Any other problems or conditions **not** listed above: \_\_\_\_\_

List all previous significant **injuries** and dates (broken bones, sprains, ect) \_\_\_\_\_

Other doctors you are currently seeing: \_\_\_\_\_

Have you ever been advised to have a surgical operation which has not been done? \_\_\_\_\_

Has anyone in your family had a similar foot problem? Who/What \_\_\_\_\_

HOSPITALIZATION AND SURGICAL HISTORY

List all previous surgeries or hospitalizations and dates: \_\_\_\_\_

Any problems healing? \_\_\_\_\_

**MEDICATIONS:** Please list **ALL** medications you are currently taking

<u>Medication</u>	<u>How Often Taken</u>	<u>Strength</u>	<u>Reason for Taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES**

- |                     |                |                                      |                             |
|---------------------|----------------|--------------------------------------|-----------------------------|
| ___ Aspirin         | ___ Penicillin | ___ Sulfa                            | ___ Other antibiotics _____ |
| ___ Novacaine       | ___ Iodine     | ___ Codeine                          | ___ Contrast dyes _____     |
| ___ Tape/ Band-Aids | ___ Metals     | ___ Morphine                         |                             |
| ___ Latex           | ___ Cortisone  | ___ Other (food, fabric, etc.) _____ |                             |

**SOCIAL HISTORY** (Please circle)

- Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_
- Employment: Employed-Part Time \_\_\_ Full Time \_\_\_ Not Employed \_\_\_ Retired \_\_\_ Student- Part Time \_\_\_ Full Time \_\_\_
- Use of Alcohol: Never \_\_\_ Occasionally \_\_\_ Moderate \_\_\_ Daily \_\_\_ Quantity \_\_\_\_\_
- Smoking: No \_\_\_ Previously but quit \_\_\_ Yes, Packs per day? \_\_\_\_\_
- Recreational/ Street Drug Use: \_\_\_\_\_ Never Rarely Daily
- Exercise, Sports, or Recreational Activities \_\_\_\_\_

**FAMILY HISTORY**

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

If deceased, cause of death

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**I state that the above medical information is true and accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the doctor's office of any changes in my medical status.**

\_\_\_\_\_  
Signature of Patient/Parent or Guardian

\_\_\_\_\_  
Date