PATIENT MEDICAL HISTORY FORM

NAME_____ BIRTH DATE _____ SEX: _____
HT _____WT _____ SHOE SIZE _____ REFERRED BY _____(Friend, Doctor, Sign, other)
FORMER PODIATRIST _____FAMILY PHYSICIAN_____

WHAT IS YOUR FOOT PROBLEM TODAY? _____

_____

IS THERE PAIN ASSOCIATED? Please circle all that apply: (**sharp, shooting, throbbing, tender, dull, aching, burning, itching, numbness, tingling)**

WHEN DID YOU FIRST NOTICE THIS PROBLEM? _____(days, weeks, months, years ago)

HAVE YOU BEEN TREATED FOR THIS? ____ YES ___ NO BY WHOM?_____ HOW LONG AGO? _____

IS THIS A WORK OR AUTO RELATED INJURY? _____ WHERE?_____ (work, auto, etc.)

I AM ALLERGIC TO please list reaction:

___ Penicillin	___ Aspirin/ Motrin	___ Adhesive tape	___**None of these**
___ Sulfa drugs	___ Cortisone	___ Codeine	
___ Novocaine	___ Demerol	___ Morphine	
___ Other Anesthetics	___ Iodine, shrimp	___ Latex	

ANY OTHER ALLERGIES: _____

CURRENT MEDICATIONS please include over the counter, vitamins, herbs:

_____ _____ _____
_____ _____ _____

DID YOU HAVE VASCULAR BY-PASS? ☐ YES ☐ NO

DO YOU HAVE JOINT IMPLANTS? ☐ YES ☐ NO If yes, Where? _____

DO YOU HAVE REPLACEMENT HEART VALVES? ____YES____ NO

WOMEN: Are you Pregnant? ___YES___ NO Date of Last Menstrual Period _____

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR: (please check)

_____ Diabetes	_____ Kidney Disease	_____ Urinary Problems
_____ High Cholesterol	_____ Cancer (explain)_____	_____ Lyme's Disease
_____ High Blood Pressure	_____ Gout	_____ Bowel /Colon Problems
_____ Heart Condition	_____ Liver Disease/ Hepatitis	_____ Rash/Skin Problems
_____ Chest Pain	_____ Arthritis	_____ Keloid/Thick Scar
_____ Heart Attack	_____ Lupus	_____ Allergies/Hay Fever
_____ Stroke	_____ Stomach Ulcers	_____ Hearing Problems
_____ Poor Circulation	_____ Lung Disease/Emphysema	_____ Rheumatic Fever
_____ Phlebitis/ Varicose Veins/ Blood Clot	_____ Tuberculosis	_____ Eye Problems/ Glaucoma / Cataracts
_____ Anemia/ Bleeding Tendencies	_____ Asthma	_____ Seizures/Epilepsy
_____ Thyroid Problems	_____ Osteoporosis	_____ HIV/AIDS
_____ Numbness Foot/ Leg	_____ Low Back Pain	_____ Leg Cramps
		_____ **None of these**
_____ Other(s)_____		

PLEASE LIST ALL SURGERIES/ HOSPITALIZATION YOU HAVE HAD, AND YEAR:

_____|_____
_____|_____
_____|_____

FAMILY HISTORY:
Please mark if your family had any of these:

	(Mom/Dad/Brother/Sister)			
Heart Condition	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Foot Problems	_____	_____	_____	_____

SOCIAL HISTORY:
Check those you use ...
_____ Cigarettes How many packs/day? _____
For How many years? _____
If you quit, How long ago? _____
_____ other Tobacco
_____ Alcoholic beverages_____(Beer, Wine, Liquor)
How often?_____(daily,weekly,monthly)
_____ Recreational Drugs (marijuana, cocaine, or others) How often? _____

_____
Patient / Guardian Signature Date