

Medical Information

Name _____ Age _____ Today's Date ____/____/____

I prefer to be addressed by ____First Name ____Nickname: _____ or: Mr. / Mrs. / Ms. / Miss / Dr.

Primary Dr. _____ City/St _____ Last Exam ____/____/____

Cardio/Diabetic Dr. _____ City _____ Last Exam ____/____/____

Have you ever visited a PODIATRIST? NO ____ YES ____ City & State _____

If yes, reason for last visit: _____

REASON FOR VISIT

Main Concern/Reason for seeing the podiatrist today please check all that apply:

When did condition begin? _____ Is it getting worse? _____

____ Bunions ____ Hammertoes ____ Planter Fasciitis ____ Shin Splints ____ Ingrown Toe Nail

____ Flat Feet ____ Gout ____ Wound ____ Fungus ____ Skin Rash

____ Other _____

Please print all MEDICAL CONDITIONS for which you are PRESENTLY being treated:

1. _____ start date of condition _____

2. _____ start date of condition _____

3. _____ start date of condition _____

4. _____ start date of condition _____

5. _____ start date of condition _____

6. _____ start date of condition _____

7. _____ start date of condition _____

8. _____ start date of condition _____

9. _____ start date of condition _____

10. _____ start date of condition _____

Please print all MEDICATIONS you are PRESENTLY taking (include PRN/as needed/occasional use & herbal supplements):

1. _____ dosage _____ how many times a day? _____

2. _____ dosage _____ how many times a day? _____

3. _____ dosage _____ how many times a day? _____

4. _____ dosage _____ how many times a day? _____

5. _____ dosage _____ how many times a day? _____

6. _____ dosage _____ how many times a day? _____

7. _____ dosage _____ how many times a day? _____

8. _____ dosage _____ how many times a day? _____

9. _____ dosage _____ how many times a day? _____

10. _____ dosage _____ how many times a day? _____

Past Surgical Procedures: _____ Approx Year _____
(If there are no surgeries, write NONE on line below)

List ALLERGIES to medications and describe reaction:
(If there are no allergies, write NONE on line below)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____ Date: _____

_____/_____/_____
Patient Name Date of Birth Today's Date

Occupation _____ Hobbies _____

CHILDHOOD DISEASES (Please circle): Measles, Mumps, Chicken pox, Rheumatic fever, birth defects _____

FAMILY HISTORY (Please circle below if Positive) OR check here _____ if family history not available/unknown

	<u>Diabetes</u>	<u>Circulatory</u>	<u>Cancer</u>	<u>High Blood Pressure</u>	<u>Heart Issues</u>	<u>If "Yes" circled, are they Alive?</u>
<u>Mother</u>	Yes	Yes	Yes	Yes	Yes	Yes / No
<u>Father</u>	Yes	Yes	Yes	Yes	Yes	Yes / No
<u>Brother/s</u>	Yes	Yes	Yes	Yes	Yes	Yes / No
<u>Sister/s</u>	Yes	Yes	Yes	Yes	Yes	Yes / No

SOCIAL HISTORY (Please Circle):

Current Smoker? No Yes Cigarettes Cigars Pipe How much? _____ packs/day How many years? _____
Former Smoker? No Yes How much? _____ packs/day How many years? _____ Age quit? _____
Alcohol: No Yes How many drinks? _____ beer/ _____ wine/ _____ hard liquor per day/week/month/year
Recreational Drugs? No Yes Former Use (list) _____

Please Circle "Yes" or "No" to indicate if you have or had any of the following problems or conditions:

CARDIOVASCULAR			GASTROINTESTINAL		
Yes	No	High blood pressure	Yes	No	Stomach Ulcers
Yes	No	Heart attack-When?	Yes	No	Liver Problems
Yes	No	Heart murmur	Yes	No	GERD/Gallbladder Problems (circle which)
Yes	No	Swelling in legs	Yes	No	Colon Problems
Yes	No	Congestive Heart Failure	Yes	No	Diverticulitis
Yes	No	Irregular Heart Rhythm	Yes	No	IBS/Crohn's Disease (circle which)
Yes	No	Pacemaker/Stent (please circle which)	Yes	No	Renal/Dialysis
Yes	No	Mitral Valve Prolapse	IMMUNOLOGIC/HEMATOLOGIC		
Yes	No	Blood Clots	Yes	No	Chemotherapy (Active or Former treatment)
Yes	No	Varicose Veins	Yes	No	Anemia/Blood Disorder
Yes	No	Coronary Artery Disease	Yes	No	Hepatitis A / B / C (please circle which)
Yes	No	High Cholesterol	Yes	No	HIV
Yes	No	Valve Replace/Vascular Graft (circle which)	Yes	No	Abnormal Bleeding/Bruising/Healing(circle)
ENDOCRINE			PSYCHIATRIC		
Yes	No	Diabetes Insulin/Non-insulin?(circle one)	Yes	No	Depression/Anxiety (please circle which)
Yes	No	Thyroid Problems	Yes	No	Memory Problems/Alzheimer's(circle which)
RESPIRATORY			NEUROLOGICAL		
Yes	No	Shortness of breath	Yes	No	Multiple Sclerosis/Parkinson's (circle which)
Yes	No	Asthma	Yes	No	Restless Leg Syndrome
Yes	No	COPD/chronic obstructive pulmonary disease	Yes	No	Tremors
Yes	No	Tuberculosis	Yes	No	Numbness or Tingling-Where?
Yes	No	Bronchitis/pneumonia (please circle which)	Yes	No	Stroke-When?
Yes	No	Emphysema	Yes	No	Seizures/Epilepsy (please circle which)

EYES/EARS/NOSE/THROAT/SKIN/HEAD (Please Circle):	Yes	No	Paralysis
Yes	No	Loss in Hearing	MUSCULOSKELETAL

Yes	No	Ring in the ears	Yes	No	Ankle/Foot Pain Limiting Activities
Yes	No	Hearing Aids	Yes	No	Arthritis? Gouty/Osteo/Rheumatoid (circle)
Yes	No	Cataracts	Yes	No	Artificial Joint-Where?
Yes	No	Glaucoma	Yes	No	Cramps in Legs/Feet
Yes	No	Glasses or Contacts (please circle which)	Yes	No	Falling 2 or more times in last 12 months
Yes	No	Dentures	Yes	No	Pain in calves/buttocks when walking
Yes	No	Headaches/Migraines (please circle which)	Yes	No	Walking difficulty
Yes	No	Vertigo	OTHER		
Yes	No	Fainting Spells	Yes	No	Cancer-What type?
Yes	No	Sinus Problems	Yes	No	Abnormal Eating/Sleeping Habits (circle)
Yes	No	Frequent Nosebleeds	Yes	No	Recent Weight Gain-How Much? lbs.
Yes	No	Any Skin Problems (List)	Yes	No	Recent Weight Loss-How Much? lbs.
Additional Info Not Listed:			Yes	No	Flu Vaccine this Season?
			Yes	No	Pneumonia Vaccine

Signature: _____ Date: _____