Patient Medical History

Name:_____ **DOB**:____/____/____ **Todays Date**:___/___/____

Age:_____ **Height**:_____ **Weight**:_____ **Shoe Size**:_____

Chief Complaint: (for todays visit)_____

Location:_____ **Type of pain:**_____
Severity of pain: ____/10 **How long have you had it? _____**
When is your pain at its worst?_____
What treatments have your tried?_____
What makes it feel better?_____
What makes it feel worse?_____

Current Medication/Dosage/Frequency: **Reason for taking it:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking Aspirin, Coumadin or Vitamin E? _____

Medication Allergies (hives, skin rash, anaphylaxis) **___No known Allergies**
___ Local anesthetics **____Latex** **___ Iodine** **___Codeine**
___ Adhesive tape **___ Anti-inflammatory Meds** **___ Antibiotics:_____**
___ Other Medications:_____

Type of reaction:_____

Past Surgeries/date:

_____ _____
_____ _____
_____ _____

Family History (circle all the apply)
Diabetes **Cancer**
Heart disease **Arthritis**
High blood pressure **Gout**

Social History (circle all the apply)
Tobacco use: Smoke/chew **How many?_____** **How many years?_____**
Alcohol use: **How much?_____**
Non-prescription drug use? _____

Review of Systems

Do you or have you had any of the following symptoms? (Circle all that apply)

General: recent weight change, weakness, fatigue, fever

Immune System: Aids, HIV, chemotherapy, immune depression

Skin: rashes, lumps, itching, dryness, color change, changes in hair or nails, excessive scarring

Eyes: legally blind, poor vision, contacts/glasses, pain redness, excessive tearing, double vision, glaucoma, cataracts, macular degeneration

Endocrine: thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst, hunger or urination

Cardiac: heart trouble, Heart attack, bypass surgery, high blood pressure, rheumatic fever, heart murmur, shortness of breath, swelling, chest pain, palpitations, and stroke

Gastrointestinal: GERD, trouble swallowing, heartburn, appetite, nausea, vomiting, vomiting of blood, indigestion, change in bowel movement, rectal bleeding, black tarry stools, constipation, diarrhea, abdominal pain, food intolerance, jaundice, liver or gall bladder trouble, hepatitis

Urinary: increase/decreased frequency of urination, blood in urine, urinary infections, kidney stones, kidney failure/disease

Musculoskeletal: joint pain/stiffness, arthritis, muscle pain or cramps, gout, backache, broken bones

If present, describe location and symptoms

_____

_____

Peripheral vascular: thrombophlebitis, varicose veins, cramps in legs at night or when walking, discoloration of feet or legs, easy bruising or excessive bleeding

Pregnancies: Are you Pregnant? _____

Number of pregnancies: _____ Number of deliveries: _____

Respiratory: asthma, emphysema, tuberculosis

Other: venereal disease, alcoholism, seizures, cancer, depression, anxiety, multiple sclerosis

Mental illness, _____

Previous podiatrist: _____