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| Patient Name: | | | | | September 19, 2022 | | |
| **MEDICAL HISTORY** | | | | | | | |
| MAIN REASON FOR TODAY’S VISIT? (DESCRIBE LOCATION AND NATURE OF PROBLEM) | | | | | | | |
| HOW LONG HAS THIS BEEN BOTHERING YOU? | | | | | | | |
| WHAT TREATMENTS HAVE YOU TRIED? | | | | | | | |
| **ALLERGIES:** Type of Reaction? Location?  None  Penicillin  Sulfa  Codeine  Aspirin  Tape  Latex  Iodine | | | | | | | |
| **Other Medicines, Foods:** Type of Reaction? Location? | |  | |  | | |  |
| **MEDICATIONS:** What medications are you currently taking? Dosage? (Include OTC, vitamins, herbs) | | | | | | | |
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| **PAST MEDICAL HISTORY**  Please indicate whether you have had any of the following medical conditions: | | | | | |  | **FAMILY HISTORY**  Please check if any of your family members have/had any of the following: | | | | | | | |
|  | **Yes** | **No** |  | **Yes** | **No** |  |  | | **Yes** | | **No** |  | **Yes** | **No** |
| Heart Disease/Failure |  |  | Arthritis |  |  |  | Bleeding Disorder | |  | |  | Arthritis |  |  |
| Heart Valve Replacement |  |  | Gout |  |  |  | Cancer | |  | |  | Bunion |  |  |
| Heart Attack |  |  | Fibromyalgia |  |  |  | Heart Trouble | |  | |  | Bunionette |  |  |
| Chest Pain/Angia |  |  | Osteoporosis |  |  |  | High Cholesterol | |  | |  | Flat Feet |  |  |
| Anxiety |  |  | Chronic Pain |  |  |  | High Blood Pressure | |  | |  | High Arched Feet |  |  |
| Coronary Artery Disease |  |  | Depression |  |  |  | Stroke | |  | |  | Pigeon-toed Feet |  |  |
| Pacemaker |  |  | Leg Pain |  |  |  | Diabetes | |  | |  | Hammertoes |  |  |
| High Blood Pressure |  |  | Back Pain |  |  |  | Gout | |  | |  | Chronic ingrown nails |  |  |
| High Cholesterol |  |  | Weakness In Extremities |  |  |  | Other*(Please specify):* | | | | | | | |
| Stroke/CVA/TIA |  |  | Numbness In Extremities |  |  |  |
| Shortness Of Breath |  |  | Balance Problems |  |  |  |  | | | | | | | |
| Lung Disease/ Emphysema |  |  | Diabetes:  Type1  Type 2 | | |  | **SOCIAL HISTORY** | | | | | | | |
| Asthma |  |  | Headaches/Migraines |  |  |  |
| Diverticulitis/Irritable Bowel |  |  | Gall Bladder disease |  |  |  |  | **Yes** | | **No** | | **Details** | | |
| GERD/Heartburn |  |  | Seizures/Epilepsy |  |  |  | Do you smoke? |  | |  | | # Years?    Packs/day: | | |
| Sleep Apnea |  |  | Changes/Loss Of Vision |  |  |  | Did you ever smoke? |  | |  | | Quit date: | | |
| Liver Disease |  |  | Stomach Ulcer |  |  |  |  |  | |  | | # Years?    Packs/day | | |
| Hepatitis |  |  | Tuberculosis |  |  |  | Caffeine? *(tea /coffee)* |  | |  | | Cups per day | | |
| Rheumatologic Disease |  |  | Sexually transmitted disease |  |  |  | Current Alcohol use? |  | |  | | #Drinks per week? | | |
| Bleeding Disorder |  |  | HIV/AIDS |  |  |  |  |  | |  | | Beer    Wine    Liquor | | |
| Clotting Disorder |  |  | Cancer *(What Type*?*)* |  |  |  | Past Alcohol use? |  | |  | | #Drinks per week? | | |
| Anemia |  |  | Thyroid Condition |  |  |  |  |  | |  | | Beer    Wine    Liquor | | |
| DVT(Blood Clot)/PE |  |  | Pregnant |  |  |  | Current or past illicit |  | |  | | Describe: | | |
| Kidney Disease/Failure |  |  | Dizziness |  |  |  | drug use/ abuse? |
| Raynaud’s Disease |  |  | Peripheral Vasc. Disease |  |  | Exercise regularly? |  | |  | | Describe: | | |
| Neuromuscular Disorders |  |  | Varicose Veins |  |  | Where Born | | | | | | | |
| Arrhythmia |  |  | Skin Conditions: |  |  | Occupation | | | | | | | |
| Alzheimer’s |  |  | Heart Murmur |  |  |  | Recent Travel Abroad? | | | | | | | |
| Fractures (When/Where?) | | | | | |  | Other Pertinent Social History Details | | | | | | | |
| Joint Replacement (Which?) | | | | | |  |
| Other Condition(s) | | | | | |  |

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| **PAST SURGICAL & HOSPITALIZATION HISTORY** | | | |
| **Procedure** | **Year** | **Hospitalizations (reason)** | **Year** |
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| **HEIGHT:** | **WEIGHT:** | **BP:** | **PULSE:** | **SHOE SIZE:** |

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

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| SIGNATURE OF PATIENT (OR GUARDIAN): |  | DATE: |  |