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| **Name:** | Click here to enter text. | **DOB:** | Choose your birthdate. | **Date:** | Choose today’s date. |

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| **Name of Primary Care Provider:** | Click here to enter text. |

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| **GENERAL** |
|  | **Yes** | **No** |  | **Yes** | **No** |
| **Have you ever seen a podiatrist in the past?** |[ ] [ ]  **Have you been hospitalized for any reason?** |[ ] [ ]
| **Are you a victim of violence or abuse?** |[ ] [ ]  *If yes:* |
|  |  |  | Date:  | Reason? |
|  |  |  | Click here to enter a date. | Enter Reason Here |
|  |  |  |  |  |
| **Do you use alcohol?** |[ ] [ ]  **Recent travel outside the United States?** |[ ] [ ]
|  |  |  | *If yes:* |  |  |
| *If yes,* how much per day? |  | Date:Click here to enter a date. | Reason:Enter Reason Here. |
| **Do you smoke cigarettes?** |[ ] [ ]  **History of or present cancer?** |[ ] [ ]
| *If yes*, Packs per day? |  | Years? |  | *If yes*, Radiation? |[ ] [ ]
| **IV drug use?** |[ ] [ ]  *If yes*, Chemotherapy?*If yes,* What kind of Cancer?  |[ ] [ ]

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| **PREVENTION** |
| **Last Flu Shot** | **Date:** | Click here to enter a date. | **Last Dental Exam** | **Date:** | Click here to enter a date. |
| **Pneumonia Shot** | **Date:** | Click here to enter a date. | **Mammogram/PSA** | **Date:** | Click here to enter a date. |
| **Shingles Shot** | **Date:** | Click here to enter a date. | **Colonoscopy** | **Date:** | Click here to enter a date. |
| **Tetanus/Pertussis/Diphtheria** | **Date:** | Click here to enter a date. | **Last Eye Exam** | **Date:** | Click here to enter a date. |

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| **HISTORY** |
|  | **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |
| **General/Constitutional** | **Ears, Eyes, Nose, Throat** | **Cardio/Pulmonary** |
| **Recent Weight Change** |[ ] [ ]  **Wear Glasses or Contacts** |[ ] [ ]  **Chest Pain** |[ ] [ ]
| **Swollen Glands** |[ ] [ ]  **Vision Changes** |[ ] [ ]  **History of Heart Attack** |[ ] [ ]
| **Fatigue** |[ ] [ ]  **Macular Degeneration** |[ ] [ ]  **Sudden Heartbeat Changes** |[ ] [ ]
| **Endocrine** |[ ] [ ]  **Glaucoma** |[ ] [ ]  **Atrial Fibrillation**  |[ ] [ ]
| **Diabetes****If yes: Type 1** [ ]  **Type 2** [ ]  |[ ] [ ]  **Hearing Loss** |[ ] [ ]  **Swelling of feet/legs or hands** |[ ] [ ]
| **Thyroid Disorder** |[ ] [ ]  **Vertigo** |[ ] [ ]  **High Blood Pressure** |[ ] [ ]
|  |  | **Low Blood Pressure** |[ ] [ ]
| **Skin** | **Neurologic** | **High Cholesterol** |[ ] [ ]
| **Non-healing Wounds** |[ ] [ ]  **Stroke** |[ ] [ ]  **Asthma** |[ ] [ ]
| **Change in hair, nails, or skin** |[ ] [ ]  **Transient Ischemic Attack** |[ ] [ ]  **Shortness of Breath** |[ ] [ ]
| **Rash or Itching** |[ ] [ ]  **Fainting** |[ ] [ ]  **COPD** |[ ] [ ]
|  | **Seizures** |[ ] [ ]  **Tuberculosis** |[ ] [ ]
| **GI/GU** | **Headaches** |[ ] [ ]  **Sleep Apnea** |[ ] [ ]
| **Kidney Disease** |[ ] [ ]  **Neuropathy** |[ ] [ ]   |
| **Ulcerative Colitis or Chrons** |[ ] [ ]  **Memory Loss** |[ ] [ ]  **Psychiatric** |
| **Urinary Tract Infection** |[ ] [ ]  **Dementia** |[ ] [ ]  **Depression** |[ ] [ ]
|  |  | **Anxiety** |[ ] [ ]
| **Circulatory** | **Muscoskeletal** | **Bipolar Disorder** |[ ] [ ]
| **History of Phlebitis** |[ ] [ ]  **Artificial Joints****If yes, specify:** |[ ] [ ]  **Schizophrenia** |[ ] [ ]
| **Tired Legs** |[ ] [ ]  **Osteoarthritis** |[ ] [ ]  **Chemical Dependency** |[ ] [ ]
| **Peripheral Vascular Disease** |[ ] [ ]  **Rheumatoid Arthritis** |[ ] [ ]   |
| **Pain in Legs with Ambulation** |[ ] [ ]  **Foot or Toe Deformity** |[ ] [ ]  **Hematologic** |
| **Pain in Legs at Rest** |[ ] [ ]  **Gout** |[ ] [ ]  **Anemia** |[ ] [ ]
| **Varicose Veins** |[ ] [ ]  **Falls** |[ ] [ ]  **Taking a Blood Thinner** |[ ] [ ]
| **History of Blood Clot** |[ ] [ ]  **Restless Leg Syndrome** |[ ] [ ]  **Bleeding Disorders** |[ ] [ ]
| **Stents****If yes, location:**  |[ ] [ ]  **Chronic Back Pain** |[ ] [ ]  **Liver Disease** |[ ] [ ]
|  |  | **HIV** |  |  |

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| **Significant Medical Family History:** | Click here to enter text. |

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| **Patient Name:** | Click here to enter text. |

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| **SURGERIES** |
| **Date:** | **Procedure:** |
| Click here to enter a date. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. |
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| Click here to enter a date. | Click here to enter text. |

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| **ALLERGIES** |
| **Medication/Anesthetic Allergies:** | Please list all known allergies. |

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| **MEDICATION LIST** |
| **Medication:** | **Dose:** | **Doses Per Day:** |
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| **Patient Signature:** |  | **Date:** |  |
| **Nurse Practitioner Signature:** |  | **Date:** |  |
| **Review Date and Initials** |  |  |  |