HERMES HEALTHCARE LLC
1900 N. Amidon - Suite 210 - Wichita, Kansas 67203

PATIENT MEDICAL HISTORY

Name: _____ **DOB:** _____ **Date:** _____

Name of Primary Care Provider: _____

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?		
Do you use alcohol? *If yes,* how much per day?	☐	☐	**Recent travel outside the United States?** *If yes:* Date: Reason:	☐	☐
Do you smoke cigarettes? *If yes*, Packs per day? Years?	☐	☐	**History of or present cancer?** *If yes*, Radiation?	☐ ☐	☐ ☐
IV drug use?	☐	☐	*If yes*, Chemotherapy? *If yes,* What kind of Cancer?	☐	☐

PREVENTION

Last Flu Shot	**Date:**		**Last Dental Exam**	**Date:**	
Pneumonia Shot	**Date:**		**Mammogram/PSA**	**Date:**	
Shingles Shot	**Date:**		**Colonoscopy**	**Date:**	
Tetanus/Pertussis/Diphtheria	**Date:**		**Last Eye Exam**	**Date:**	

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PATIENT MEDICAL HISTORY

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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PATIENT MEDICAL HISTORY

Significant Medical Family History: _____

Patient Name: _____

SURGERIES	
Date:	**Procedure:**

ALLERGIES	
Medication/Anesthetic Allergies:	

MEDICATION LIST		
Medication:	**Dose:**	**Doses Per Day:**

Patient Signature: _____ **Date:** _____

Nurse Practitioner Signature: _____ **Date:** _____

Review Date and Initials _____