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

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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? | |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |  |  |

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

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

|  |  |
| --- | --- |
| **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. |
| Click here to enter a date. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. |

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Signature:** |  | **Date:** |  |
| **Nurse Practitioner Signature:** |  | **Date:** |  |
| **Review Date and Initials** |  |  |  |