

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?	<input type="checkbox"/>	<input type="checkbox"/>	Have you been hospitalized for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a victim of violence or abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes:</i> Date: _____ Reason? _____		
Do you use alcohol? <i>If yes, how much per day?</i>	<input type="checkbox"/>	<input type="checkbox"/>	Recent travel outside the United States? <i>If yes:</i> Date: _____ Reason: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes? <i>If yes, Packs per day? Years?</i>	<input type="checkbox"/>	<input type="checkbox"/>	History of or present cancer? <i>If yes, Radiation?</i>	<input type="checkbox"/>	<input type="checkbox"/>
IV drug use?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, Chemotherapy?</i>	<input type="checkbox"/>	<input type="checkbox"/>
			<i>If yes, What kind of Cancer?</i>		

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:	

PATIENT MEDICAL HISTORY

HISTORY								
	Yes	No		Yes	No		Yes	No
General/Constitutional			Ears, Eyes, Nose, Throat			Cardio/Pulmonary		
Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Wear Glasses or Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	History of Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Heartbeat Changes	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes If yes: Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet/legs or hands	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
						Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Skin			Neurologic			High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Non-healing Wounds	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Change in hair, nails, or skin	<input type="checkbox"/>	<input type="checkbox"/>	Transient Ischemic Attack	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Rash or Itching	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
GI/GU			Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
Ulcerative Colitis or Chrons	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
						Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory			Musculoskeletal			Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
History of Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints If yes, specify:	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Tired Legs	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic		
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in Legs with Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Toe Deformity	<input type="checkbox"/>	<input type="checkbox"/>			

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Pain in Legs at Rest	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Falls	<input type="checkbox"/>	<input type="checkbox"/>	Taking a Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>
History of Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Restless Leg Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Stents If yes, location:	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
						HIV		

Significant Medical Family History:	

Patient Name: _____

SURGERIES

Date:	Procedure:

ALLERGIES

Medication/Anesthetic Allergies:	Please list all known allergies.
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MEDICATION LIST

Medication:	Dose:	Doses Per Day:

PATIENT MEDICAL HISTORY

Patient Signature: _____ **Date:** _____
Nurse Practitioner Signature: _____ **Date:** _____
Review Date and Initials _____