

MEDICAL HISTORY

PLEASE CHECK ANY MEDICAL PROBLEMS YOU MAY HAVE:

HEART

- HEART ATTACK
- ANGINA, CHEST PAIN
- IRREGULAR PULSE/PALPITATIONS
- RHEUMATIC FEVER
- HEART MURMUR
- HEART VALVE PROBLEM
- BLOOD PRESSURE

NEUROLOGICAL

- STROKE
- FAINTING SPELLS, DIZZINESS
- EPILEPSY, CONVULSIONS
- MENTAL ILLNESS
- PARKINSONISM
- HEADACHES

ENDOCRINE

- THYROID PROBLEMS
- DIABETES
- LAST BLOOD SUGAR READING _____

BREATHING

- ASTHMA
- EMPHYSEMA, BRONCHITIS
- TUBERCULOSIS
- BLOOD CLOT IN LUNGS
- SLEEP APNEA DISORDERS

STOMACH/DIGESTIVE

- ULCERS/HIATAL HERNIA
- DIARRHEA COLITIS
- HEPATITIS
- NAUSEA/VOMITING

SKELETAL/MUSCLE

- ARTHRITIS
- NUMBNESS/TINGLING
- BACK PAIN OR INJURY
- MUSCLE WEAKNESS
- BLOOD CLOTS IN LEGS
- OTHER _____
- _____

SIGNS OF INFECTION

- FEVER
- NIGHT SWEATS
- PERSISTENT COUGH
- WEIGHT LOSS
- BLOODY SPUTUM
- LOSS OF APPETITE

OTHER

- SWALLOWING/CHEWING
- ALCOHOL/DRUG ADDICTION
- SICKLE CELL DISEASE
- PREGNANCY COMPLICATION
- BLEEDING OR EASY BRUISING
- HEARING LOSS
- OTHER _____

FAMILY PHYSICIAN: _____

LAST VISIT DATE _____

HAVE YOU BEEN TO A PODIATRIST BEFORE? NAME: _____

LAST VISIT DATE: _____

I WOULD LIKE THE DR. TO TAKE CARE OF THE FOLLOWING PROBLEM _____

HOW LONG HAS IT BOTHERED YOU _____ DAYS _____ WEEKS _____ MONTHS (CIRCLE ONE)

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS OR ADHESIVE TAPE? PLEASE LIST TYPE (WHAT HAPPENS): _____

WHAT OPERATIONS/INJURIES HAVE YOU HAD? LIST APPROXIMATE YEAR: _____

THE FOLLOWING INFORMATION IS IMPORTANT IN PREVENTING DRUG INTERACTIONS:

DO YOU SMOKE? YES NO HOW MUCH _____

DO YOU DRINK? YES NO HOW MUCH _____

DRUG USE? YES NO

ARE YOU POSSIBLY PREGNANT? YES NO

HEIGHT: _____ WEIGHT: _____

PLEASE LIST THE MEDICATIONS PRESENTLY TAKING.	DOSE	REASON TAKEN
CURRENT MEDICATION		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____