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| Patient Name:       | September 19, 2022 |
| **MEDICAL HISTORY** |
| MAIN REASON FOR TODAY’S VISIT? (DESCRIBE LOCATION AND NATURE OF PROBLEM)       |
| HOW LONG HAS THIS BEEN BOTHERING YOU?       |
| WHAT TREATMENTS HAVE YOU TRIED?       |
| **ALLERGIES:** Type of Reaction? Location? [ ]  None [ ]  Penicillin [ ]  Sulfa [ ]  Codeine [ ]  Aspirin [ ]  Tape [ ]  Latex [ ]  Iodine  |
| **Other Medicines, Foods:** Type of Reaction? Location? | 1.
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| **MEDICATIONS:** What medications are you currently taking? Dosage? (Include OTC, vitamins, herbs) |
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| **PAST MEDICAL HISTORY**Please indicate whether you have had any of the following medical conditions: |  | **FAMILY HISTORY**Please check if any of your family members have/had any of the following: |
|   | **Yes** | **No** |  | **Yes** | **No** |  |  | **Yes** | **No** |  | **Yes** | **No** |
| Heart Disease/Failure | [ ]  | [ ]  | Arthritis  | [ ]  | [ ]  |  | Bleeding Disorder | [ ]  | [ ]  | Arthritis | [ ]  | [ ]  |
| Heart Valve Replacement | [ ]  | [ ]  | Gout | [ ]  | [ ]  |  | Cancer | [ ]  | [ ]  | Bunion | [ ]  | [ ]  |
| Heart Attack | [ ]  | [ ]  | Fibromyalgia  | [ ]  | [ ]  |  | Heart Trouble | [ ]  | [ ]  | Bunionette | [ ]  | [ ]  |
| Chest Pain/Angia | [ ]  | [ ]  | Osteoporosis | [ ]  | [ ]  |  | High Cholesterol | [ ]  | [ ]  | Flat Feet | [ ]  | [ ]  |
| Anxiety | [ ]  | [ ]  | Chronic Pain | [ ]  | [ ]  |  | High Blood Pressure | [ ]  | [ ]  | High Arched Feet | [ ]  | [ ]  |
| Coronary Artery Disease | [ ]  | [ ]  | Depression  | [ ]  | [ ]  |  | Stroke | [ ]  | [ ]  | Pigeon-toed Feet | [ ]  | [ ]  |
| Pacemaker | [ ]  | [ ]  | Leg Pain | [ ]  | [ ]  |  | Diabetes | [ ]  | [ ]  | Hammertoes | [ ]  | [ ]  |
| High Blood Pressure | [ ]  | [ ]  | Back Pain  | [ ]  | [ ]  |  | Gout | [ ]  | [ ]  | Chronic ingrown nails | [ ]  | [ ]  |
| High Cholesterol | [ ]  | [ ]  | Weakness In Extremities | [ ]  | [ ]  |  | Other*(Please specify):*       |
| Stroke/CVA/TIA | [ ]  | [ ]  | Numbness In Extremities | [ ]  | [ ]  |  |
| Shortness Of Breath | [ ]  | [ ]  | Balance Problems | [ ]  | [ ]  |  |  |
| Lung Disease/ Emphysema | [ ]  | [ ]  | Diabetes: [ ]  Type1 [ ]  Type 2 |  | **SOCIAL HISTORY** |
| Asthma | [ ]  | [ ]  | Headaches/Migraines | [ ]  | [ ]  |  |
| Diverticulitis/Irritable Bowel | [ ]  | [ ]  | Gall Bladder disease | [ ]  | [ ]  |  |  | **Yes** | **No** | **Details** |
| GERD/Heartburn | [ ]  | [ ]  | Seizures/Epilepsy | [ ]  | [ ]  |  | Do you smoke? | [ ]  | [ ]  | # Years?    Packs/day:     |
| Sleep Apnea | [ ]  | [ ]  | Changes/Loss Of Vision | [ ]  | [ ]  |  | Did you ever smoke? | [ ]  | [ ]  | Quit date:    |
| Liver Disease | [ ]  | [ ]  | Stomach Ulcer | [ ]  | [ ]  |  |  |  |  | # Years?    Packs/day    |
| Hepatitis | [ ]  | [ ]  | Tuberculosis | [ ]  | [ ]  |  | Caffeine? *(tea /coffee)* | [ ]  | [ ]  | Cups per day    |
| Rheumatologic Disease | [ ]  | [ ]  | Sexually transmitted disease | [ ]  | [ ]  |  | Current Alcohol use? | [ ]  | [ ]  | #Drinks per week?    |
| Bleeding Disorder | [ ]  | [ ]  | HIV/AIDS | [ ]  | [ ]  |  |  |  |  |    Beer    Wine    Liquor |
| Clotting Disorder | [ ]  | [ ]  | Cancer *(What Type*?*)* | [ ]  | [ ]  |  | Past Alcohol use? | [ ]  | [ ]  | #Drinks per week?    |
| Anemia | [ ]  | [ ]  | Thyroid Condition  | [ ]  | [ ]  |  |  |  |  |    Beer    Wine    Liquor |
| DVT(Blood Clot)/PE | [ ]  | [ ]  | Pregnant | [ ]  | [ ]  |  | Current or past illicit | [ ]  | [ ]  | Describe:       |
| Kidney Disease/Failure | [ ]  | [ ]  | Dizziness | [ ]  | [ ]  |  | drug use/ abuse? |
| Raynaud’s Disease | [ ]  | [ ]  | Peripheral Vasc. Disease | [ ]  | [ ]  | Exercise regularly? | [ ]  | [ ]  | Describe:       |
| Neuromuscular Disorders | [ ]  | [ ]  | Varicose Veins | [ ]  | [ ]  | Where Born       |
| Arrhythmia | [ ]  | [ ]  | Skin Conditions:       | [ ]  | [ ]  | Occupation       |
| Alzheimer’s | [ ]  | [ ]  | Heart Murmur | [ ]  | [ ]  |  | Recent Travel Abroad?       |
| Fractures (When/Where?)       |  | Other Pertinent Social History Details       |
| Joint Replacement (Which?)       |  |
| Other Condition(s)       |  |

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| **PAST SURGICAL & HOSPITALIZATION HISTORY** |
| **Procedure** | **Year** | **Hospitalizations (reason)** | **Year** |
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| **HEIGHT:**       | **WEIGHT:**       | **BP:**       | **PULSE:**       | **SHOE SIZE:**       |

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

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| SIGNATURE OF PATIENT (OR GUARDIAN): |  | DATE: |  |