

**PATIENT MEDICAL HISTORY FORM**

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX: \_\_\_\_\_  
HT \_\_\_\_\_ WT \_\_\_\_\_ SHOE SIZE \_\_\_\_\_ REFERRED BY \_\_\_\_\_ (Friend, Doctor, Sign, other)  
FORMER PODIATRIST \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

.....  
**WHAT IS YOUR FOOT PROBLEM TODAY?** \_\_\_\_\_

**Is there pain associated?** Please circle all that apply: (sharp, shooting, throbbing, tender, dull, aching, burning, itching, numbness, tingling)

WHEN DID YOU FIRST NOTICE THIS PROBLEM? \_\_\_\_\_ (days, weeks, months, years ago)  
HAVE YOU BEEN TREATED FOR THIS? \_\_\_ YES \_\_\_ NO BY WHOM? \_\_\_\_\_ HOW LONG AGO? \_\_\_\_\_  
IF AN INJURY, DATE OCCURRED \_\_\_\_\_ WHERE? \_\_\_\_\_ (work, auto, etc.)

**I AM ALLERGIC TO** please list reaction:  
\_\_\_ Penicillin                      \_\_\_ Aspirin/ Motrin                      \_\_\_ Adhesive tape                      \_\_\_ **None of these**  
\_\_\_ Sulfa drugs                      \_\_\_ Cortisone                      \_\_\_ Codeine  
\_\_\_ Novocaine                      \_\_\_ Demerol                      \_\_\_ Morphine  
\_\_\_ Other Anesthetics                      \_\_\_ Iodine, shrimp                      \_\_\_ Latex  
ANY OTHER ALLERGIES: \_\_\_\_\_

**CURRENT MEDICATIONS** please include over the counter, vitamins, herbs:  
\_\_\_\_\_  
\_\_\_\_\_

DID YOU HAVE VASCULAR BY-PASS? \_\_\_ YES \_\_\_ NO  
DO YOU HAVE JOINT IMPLANTS? \_\_\_ YES \_\_\_ NO If yes, Where: \_\_\_\_\_  
DO YOU HAVE REPLACEMENT HEART VALVES? \_\_\_ YES \_\_\_ NO

**WOMEN:** Are you Pregnant? \_\_\_ YES \_\_\_ NO Date of Last Menstrual Period \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU BEEN TREATED FOR: (please check)**

___ Diabetes	___ Kidney Disease	___ Urinary Problems
___ High Cholesterol	___ Cancer (explain) _____	___ Lyme's Disease
___ High Blood Pressure	___ Gout	___ Bowel /Colon Problems
___ Heart Condition	___ Liver Disease/ Hepatitis	___ Rash/Skin Problems
___ Chest Pain	___ Arthritis	___ Keloid/Thick Scar
___ Heart Attack	___ Lupus	___ Allergies/Hay Fever
___ Stroke	___ Stomach Ulcers	___ Hearing Problems
___ Poor Circulation	___ Lung Disease/Emphysema	___ Rheumatic Fever
___ Phlebitis/ Varicose Veins/ Blood Clot	___ Tuberculosis	___ Eye Problems/ Glaucoma / Cataracts
___ Anemia/ Bleeding Tendencies	___ Asthma	___ Seizures/Epilepsy
___ Thyroid Problems	___ Osteoporosis	___ HIV/AIDS
___ Numbness Foot/ Leg	___ Low Back Pain	___ Leg Cramps
___ Other(s) _____		___ <b>None of these</b>

**PLEASE LIST ALL SURGERIES/ HOSPITALIZATION YOU HAVE HAD, AND YEAR:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:**  
Please mark if your family had any of these:  
(Mom/Dad/Brother/Sister)  
Heart Condition . . . . . \_\_\_\_\_  
High Blood Pressure . . . . . \_\_\_\_\_  
Stroke . . . . . \_\_\_\_\_  
Cancer . . . . . \_\_\_\_\_  
Diabetes . . . . . \_\_\_\_\_  
Foot Problems . . . . . \_\_\_\_\_

**SOCIAL HISTORY:**  
Check those you use ...  
\_\_\_ Cigarettes How many packs/day? \_\_\_\_\_  
For How many years? \_\_\_\_\_  
If you quit, How long ago? \_\_\_\_\_  
\_\_\_ other Tobacco  
\_\_\_ Alcoholic beverages \_\_\_\_\_ (Beer, Wine, Liquor)  
How often? \_\_\_\_\_ (daily, weekly, monthly)  
\_\_\_ Recreational Drugs (marijuana, cocaine, or others) How often? \_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature                      Date

\_\_\_\_\_  
Patient / Guardian Signature                      Date