

Medical History

Please check "Yes" or "No" to indicate if you have had any of the following problems:

Yes	No	Nature of Problem	Comments & Give Approximate Date
		Recent Weight Loss	
		Headache	
		Trouble with Vision	
		Trouble with Hearing	
		Allergies/Hay Fever	
		Asthma	
		Allergic Reaction to Medications	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/ Heart Murmur	
		Circulation	
		High Blood Pressure	
		Chest Pain	
		Lungs (Pneumonia, TB, ect.)	
		Shortness of Breath (Coughing, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease (or Jaundice)	
		Stomach Trouble	
		Swelling in Feet or Ankles	
		Arthritis	

Are you on any current medications? Yes No (circle one)

If yes, complete medication sheet.

Yes	No	Nature Of Problem	Comments and Give Approximate Date
		Kidney Disease or Stones	
		Gout	
		Bleeding Tendency	
		Scarring Tendency	
		Join Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or legs	
		Low Back Pain	
		Do you Smoke? How Much?	
		Do you drink alcohol? How much?	
		Prior Surgeries	
		Psychiatric Problems	
		Fainting or Convulsions	
		Stroke	
		High Cholesterol	
		Other illnesses or Problems	
		HIV Positive	

Indicate which of your immediate relatives have had any of the following diseases:

Cancer _____ Diabetes _____
 Heart Trouble _____ High Blood Pressure _____
 Kidney Disease _____ Mental/Emotional Disease _____
 Stroke _____ Arthritis _____

Former Podiatrist _____

Why did you see your former Podiatrist? _____

What problems bring you to our office _____

 Patient Signature _____ Date _____