PODIATRY/ORTHOPEDICS MEDICAL HISTORY

Today's Date:_____/_____/_____
Month Day Year

PATIENT INFORMATION

Name: *(First)* _____ *(Middle Initial)* ___ *(Last)* _____

Birth Date: ____/____/_____ Weight:_____ Height:_____ Shoe Size:_____

Prescription Medications/Supplements: ☐None _____

_____

Preferred Pharmacy:_____

Allergies: ☐None ☐Latex ☐Adhesive ☐Medication:_____

☐Other:_____

Serious Injuries/Illnesses/Medical Concerns:_____

Hospitalizations or Surgeries:_____

_____

FAMILY HISTORY:

Is there family history of one of the following?

Arthritis: ☐Yes ☐No ☐Unknown

(*if yes, please explain the condition and relative):*_____

_____

Heart Disease: ☐Yes ☐No ☐Unknown

(*if yes, please explain the condition and relative):*_____

_____

Diabetes: ☐Yes ☐No ☐Unknown

(*if yes, please explain the condition and relative):*_____

_____

Cancer: ☐Yes ☐No ☐Unknown

(*if yes, please explain the condition and relative):*_____

_____

LIFESTYLE FACTORS:

Alcohol: ☐ Yes ☐ No *(If yes, how often?)* _____

Caffeine: ☐ Yes ☐ No *(If yes, how often?)* _____

Rec.Drugs: ☐ Yes ☐ No *(If yes, how often?)* _____

Tobacco: ☐ Yes ☐ No *(If yes, how many packs/day?)* _____

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PODIATRY/ORTHOPEDICS MEDICAL HISTORY

MEDICAL HISTORY:

☐ **NONE**

☐ AIDS/HIV/Venereal Disease	☐ Blood Clots	☐ Heart Disease	☐ Psychiatric Care
	☐ Cancer	☐ Hepatitis or Liver Disease	☐ Respiratory Disease
☐ Anemia	☐ Chemical Dependency	☐ High Blood Pressure	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Kidney Problems	☐ Stroke
☐ Bladder Infection	☐ Glaucoma	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gout	☐ Prostate Problems	☐ Ulcers

REVIEW OF CURRENT SYMPTOMS:

(Check all that apply) ☐ **NONE**

GENERAL:	☐ Fever	☐ Chills	☐ Weight Loss	☐ Weight Gain
EYES:	☐ Blurred Vision	☐ Double Vision	☐ Poor Vision	☐ Glasses
EARS/NOSE/THROAT:	☐ Ringing in Ears	☐ Sinus Congestion	☐ Hearing Loss	☐ Sore Throat
HEART:	☐ Chest Pain	☐ Irregular Heart Beat	☐ Palpations	
LUNGS:	☐ Cough	☐ Shortness of Breath	☐ Difficulty Breathing	
INTESTINAL:	☐ Upset Stomach	☐ Bloody Stools	☐ Constipation	☐ Diarrhea
URINARY:	☐ Burning	☐ Frequent Urination	☐ Incontinence	
MUSCULOSKELETAL:	☐ Joint Pain	☐ Muscle Weakness	☐ Joint Stiffness	☐ Swelling
SKIN:	☐ Rashes	☐ Sores	☐ Masses	☐ Scars
NEUROLOGICAL:	☐ Tremors	☐ Numbness	☐ Poor Balance	☐ Dizziness
PSYCHIATRIC:	☐ Depression	☐ Mood Swings	☐ Anxiety	
ENDOCRINE:	☐ Hair Loss	☐ Excessive Thirst	☐ Fatigue	☐ Diabetes
BLOOD/LYMPHATIC:	☐ Leg Swelling	☐ Bleeding Tendency	☐ Bruise Easily	☐ Anemia
OB/GYN:	☐ Pregnant	☐ Birth Control Pills	☐ Hormone Therapy	☐ Menopausal

Other Symptoms or Concerns: *(Not listed above)* _____

Duration of Symptoms: *(This episode)* _____

What makes the symptoms:

Worse: _____

Better: _____

SIGNATURES

_____ ____/____/____

Patient – Age 18 or older *Month Day Year*

_____ ____/____/____

Parent/Guardian - If patient is under age 18 *Month Day Year*

_____ ____/____/____

Provider Signature *Month Day Year*