Advanced Podiatry Patient History Form

PERSONAL INFORMATION:

Patient Name _____ Age _____ DOB _____

Current Weight _____ Height _____ Shoe Size _____

Primary Care Physician _____ Date last seen _____

Referring Physician _____ Have you had a flu shot this year? ☐ Yes ☐ No

Have you had a pneumonia shot this year? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Are you Diabetic? ☐ Yes ☐ No Do you use insulin? ☐ Yes ☐ No Date of Diagnosis _____ Last A1C reading _____

Do you/have you had the following? Hepatitis ☐ Yes ☐ No HIV/AIDS? ☐ Yes ☐ No

Check each line	Yes	No	Check each line	Yes	No	Check each line	Yes	No
Amputation	____	____	COPD/Emphysema	____	____	Mitral valve prolapse	____	____
Anaphylactic reaction	____	____	Cysts	____	____	Neuropathy	____	____
Anesthesia reaction	____	____	Cystic fibrosis	____	____	Osteopenia	____	____
Anxiety disorder	____	____	Depression	____	____	Osteoporosis	____	____
Arthritis	____	____	Diabetes mellitus	____	____	Pacemaker	____	____
Asthma	____	____	Fibromyalgia	____	____	Peripheral vascular disease	____	____
Atrial fibrillation	____	____	Gout	____	____	Psoriasis	____	____
Back pain	____	____	Heart disease	____	____	Pulmonary embolism	____	____
Birth control use	____	____	High cholesterol	____	____	Reflux/heartburn	____	____
Blood clot history	____	____	High blood pressure	____	____	Rheumatoid arthritis	____	____
Broken bone	____	____	Hyperthyroidism	____	____	Seizure disorder	____	____
location _____			Hypothyroidism	____	____	Skin ulcers	____	____
Cancer	____	____	Irritable bowel syndrome	____	____	Sleep apnea/CPAP	____	____
Chemical addiction	____	____	Kidney disease	____	____	Stomach ulcers	____	____
Circulation problems	____	____	Large scars/keloids	____	____	Stroke	____	____
Clostridium Difficile Colitis	____	____	Liver condition	____	____	Tuberculosis	____	____
Congestive Heart Failure	____	____	Melanoma	____	____	Other_____		
			Menopause	____	____	_____		

List all medications you take INCLUDING THE DOSAGE AND HOW OFTEN YOU TAKE IT. (include aspirin, birth control pills, over the counter medications and supplements) **IF YOU HAVE A LIST, WE CAN MAKE A COPY.**

Medication	Dosage	How often?	Medication	Dosage	How often?
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Pharmacy_____ **Location** _____

ALLERGIES (please check)

	Yes	No	If yes, list reaction		Yes	No	If yes, list reaction
Tapes/Adhesives	____	____	_____	Penicillin	____	____	_____
Eggs	____	____	_____	Shellfish	____	____	_____
Iodine	____	____	_____	Sulfa Drugs	____	____	_____
Latex	____	____	_____	X-ray dye	____	____	_____
Nickel/metal jewelry	____	____	_____	Others _____			
NSAIDS/anti inflammatories	____	____	_____	_____			

Patient History Form Continued

PREVIOUS SURGERIES: (include any complications)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Please check ALL that apply

Alcoholism	____	Heart problems	____
Amputation	____	Kidney disease	____
Anesthesia problems	____	Liver problems	____
Arthritis	____	Lupus/autoimmune disease	____
Bleeding disorders	____	Malignant melanoma	____
Blood clots	____	Neurologic disease	____
Bunions/foot deformity	____	Peripheral vascular disease	____
Cancer	____	Pulmonary embolism	____
Diabetes mellitus	____	Rheumatoid arthritis	____
Heart disease	____	Other _____	

SOCIAL HISTORY: (circle)

Smoking Status:	Non-smoker	Former Smoker	Current Smoker
Alcohol Use:	Non-drinker	Social Drinker	Daily Use
Illegal Drug Use:	Never Used	Former User	Current User

Occupation _____ Hours per shift on your feet _____

REVIEW OF SYSTEMS: Please circle any CURRENT symptoms you are experiencing

Systemic	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
Cardiovascular	Chest pain Shortness of breath	None
Motor	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
Neurological	Numbness in feet Leg pain Back pain Para theses (nerve sensations)	None
Derm	Rash Masses Skin color changes Itching	None
Vascular	Calf/leg cramps at night Calf/leg cramps while walking Edema (swelling of legs) Cold fingers/toes Cold intolerance	None

*Please note: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

If you would like a copy of your continued care document from today, please inform the front office.

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

➔**Signature**: _____ **Date**:_____