

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? 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

<i>Systemic</i>	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
<i>Cardiovascular</i>	Chest pain Shortness of breath	None
<i>Motor</i>	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
<i>Neurological</i>	Numbness in feet Leg pain Back pain Para theses (nerve sensations)	None
<i>Derm</i>	Rash Masses Skin color changes Itching	None
<i>Vascular</i>	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:** _____