Health History Form

Today's Date _____/____/______ Patient Name ______________________________________

GENERAL INFORMATION Height: ___'______" Weight: ______lbs Shoe Size: ______ (Women Only) Pregnant? ☐ Yes ☐ No

Family Physician:______________________________ Location:____________________ Date Last Seen: ____/____/_______

Pharmacy:__________________________________ Location:____________________ Phone: (____)________________

ALLERGIES: ☐ No Known Allergies ☐ Adhesive/Tape ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Sulfa ☐ Iodine ☐ Local Anesthetics ☐ Seafood ☐ Penicillin ☐ Novocain ☐ Other:______________________________

CURRENT MEDICATIONS: Include prescriptions, over the counter medications, and vitamins______________________________

____

____

SURGERIES: Please list your major surgeries ____

____

PRIOR PATIENT & FAMILY MEDICAL HISTORY: Please indicate "Yes" if you or a family member have had any of the following:

	Patient	Family		Patient	Family		Patient	Family		Patient	Family
Aids/ HIV:	☐ Yes	☐ Yes	Diabetes:	☐ Yes	☐ Yes	High Cholesterol:	☐ Yes	☐ Yes	Parkinson's:	☐ Yes	☐ Yes
Alcoholism:	☐ Yes	☐ Yes	Dialysis	☐ Yes	☐ Yes	Immunologic Problems:	☐ Yes	☐ Yes	PVD:	☐ Yes	☐ Yes
Angina:	☐ Yes	☐ Yes	Heart Attack:	☐ Yes	☐ Yes				Seizures:	☐ Yes	☐ Yes
Asthma:	☐ Yes	☐ Yes	Heart Disease:	☐ Yes	☐ Yes	Major Trauma:	☐ Yes	☐ Yes	Stroke:	☐ Yes	☐ Yes
Cancer:	☐ Yes	☐ Yes	Hepatitis:	☐ Yes	☐ Yes	Multiple Sclerosis:	☐ Yes	☐ Yes	Thyroid Disorder:	☐ Yes	☐ Yes
Depression:	☐ Yes	☐ Yes	High Blood Pressure:	☐ Yes	☐ Yes	Obesity:	☐ Yes	☐ Yes	Tuberculosis:	☐ Yes	☐ Yes

SOCIAL HISTORY:

					Amount
Do you smoke?	___ Never	___ Quit	___ Light	___ Heavy	____pk/Day
Alcohol Use:	___ Never	___ Quit	___ Light	___ Heavy	___ Social

Vaccinations:

			Date
Flu Shot:	☐ Yes	☐ No	_________
Tetanus Shot:	☐ Yes	☐ No	_________

Office Use Only:

BP: /

Pulse:

DETAILED CURRENT MEDICAL HISTORY: Please indicate if you have the following. If your condition isn't listed, feel free to write it in.

Constitutional: (Physical/Mental Condition)
- Addiction: ☐ Yes
- Anxiety: ☐ Yes
- Headache: ☐ Yes
- Major Trauma: ☐ Yes
- Nausea /Vomiting: ☐ Yes
- No to All above: ☐ Yes

Cardiovascular: (Heart/Blood Vessels)
- Anemia: ☐ Yes
- Angina: ☐ Yes
- Bleeding Disorder: ☐ Yes
- Claudication ☐ Yes
- High Blood Pressure ☐Yes
- High Cholesterol: ☐ Yes
- Leg Pain When - Walking: ☐ Yes
- Murmur: ☐ Yes
- Pacemaker: ☐ Yes
- Peripheral - Vascular Disease: ☐ Yes
- Phlebitis: ☐ Yes
- Poor Circulation: ☐ Yes
- Stroke: ☐ Yes
- Swelling of- Foot/Ankle: ☐ Yes
- No to All above: ☐ Yes

Endocrine: (Glands/Hormones)
- Cold Intolerance: ☐ Yes
- Diabetes: ☐ Yes
- Dry Hair/Skin: ☐ Yes
- Hyperglycemia: ☐ Yes
- Hypoglycemia ☐ Yes
- Immunologic problem: ☐ Yes
- No to All above: ☐ Yes

Ears, Nose, Mouth, Throat:
- Symptoms involving: Ear, Nose, Mouth, Throat ☐ Yes
- No to All above: ☐ Yes

Eyes:
- Eye problems: ☐ Yes
- Glaucoma: ☐ Yes
- Vision problems: ☐ Yes
- No to All above: ☐ Yes

Gastrointestinal (GI): (Stomach/Intestine)
- Constipation: ☐ Yes
- Diarrhea: ☐ Yes
- Heartburn: ☐ Yes
- Negative/None: ☐ Yes

Genitourinary (GU): (Genital/Urinary System)
- Kidney Dialysis: ☐ Yes
- No to All above: ☐ Yes

Immunologic: (Immune system)
- Allergic/ Immunologic Symptoms: ☐ Yes
- AIDS/HIV: ☐ Yes
- No to All above: ☐ Yes

Integumentary/Skin:
- Athlete's Foot ☐ Yes
- Cancer, Tumors, Cysts: ☐ Yes
- Corns/Callouses: ☐ Yes
- Dermatitis: ☐ Yes
- Eczema: ☐ Yes
- Excessive Scar Tissue: ☐ Yes
- Fungus Nail/Skin: ☐ Yes
- Hives: ☐ Yes
- Ingrown Nails: ☐ Yes
- Lower Leg Ulcer: ☐ Yes
- NonHealingWound: ☐ Yes
- Plantar Warts: ☐ Yes
- Psoriasis: ☐ Yes
- Rash: ☐ Yes
- Shingles: ☐ Yes
- Skin Discoloration: ☐ Yes
- Ulceration: ☐ Yes
- No to All above: ☐ Yes

Hematologic/Lymphatic: (Blood/Lymph Systems)
- Ankle Edema: ☐ Yes
- Leg Pain: ☐ Yes
- Leg Swelling: ☐ Yes
- No to All above: ☐ Yes

Musculo/Skeletal:
- Ankle Pain: ☐ Yes
- Arthralgia ☐ Yes
- Arthritis: ☐ Yes
- Back/Neck pain: ☐ Yes
- Bunion: ☐ Yes
- Bunionette: ☐ Yes
- Fibromyalgia: ☐ Yes
- Flat Feet: ☐ Yes
- Fractures Ankle: ☐ Yes
- Fractures Foot: ☐ Yes
- Fractures Toes: ☐ Yes
- Gout: ☐ Yes
- Heel Pain: ☐ Yes
- Hip Pain: ☐ Yes
- Joint Disease: ☐ Yes
- Rheumatoid Arthritis: ☐ Yes
- Sciatica: ☐ Yes
- Scoliosis: ☐ Yes
- No to All above: ☐ Yes

Nervous:
- Headaches: ☐ Yes
- Hearing Problems: ☐ Yes
- Neurological Problems: ☐ Yes
- Numbness: ☐ Yes
- Seizure/Paralysis: ☐ Yes
- Thyroid Problems: ☐ Yes
- Tingling: ☐ Yes
- No to All above: ☐ Yes

Psychiatric: (Mental State)
- Addiction: ☐ Yes
- Anxiety: ☐ Yes
- Depression: ☐ Yes
- No to All above: ☐ Yes

Respiratory:
- Asthma: ☐ Yes
- Bronchitis: ☐ Yes
- COPD:(chronic obstructive pulmonary disease) ☐ Yes
- Emphysema: ☐ Yes
- Lung Disease: ☐ Yes
- Sleep Apnea: ☐ Yes
- Tuberculosis: ☐ Yes
- No to All above: ☐ Yes

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment of my feet.

X______________________________________ ____________________

Patient/ Guardian Signature Date