PATIENT MEDICAL HISTORY NAME:

Please circle any of the following conditions that you have or had:

Acne
Anemia
Ankle Swelling
Anxiety
Arthritis
Artificial joint replacement
Asthma
Autoimmune dz (HIV/AIDS)
Basal Cell Carcinoma
Bleeding Disorders
Cancer_____
Cataracts
Charcot foot
Chemical Dependency
Chest Pain
Circulatory Disorders
COPD
CRPS/RSD
Depression
Diabetes
Epilespy
Fibromyalgia
GI Bleeding
GI reflux/GERD
Gout
Heart Attack
Heart Disease
Hepatitis A B C D E
Hernia
High Blood Pressure
High Cholesterol
Hyperthyroid
Hypothyroid
Kidney Disease
Liver Disease
Malignant Melanoma
Mitral Valve Prolapse
Muscular Dystrophy
Pulmonay Fibrosis
Raynaud's
Rheumatoid Arthritis
Seizures
Shortness of Breath
Squamous Cell Carcinoma
Stroke
Tuberculosis
Warts
Other:

ARE YOU DIABETIC? YES____ NO____ IF YES, LAST GLUCOSE READING_____ A1c_____

PAST SURGICAL HISTORY - please list procedure & date

_____

_____

_____

FAMILY MEDICAL HISTORY

Mother Alive? Yes____ No____ Past/Med Hx_____

Father Alive? Yes____ No____ Past/Med Hx_____

# of Brothers _____ PMH_____

# of Sisters _____ PMH_____

SOCIAL HISTORY - please circle one

Single. Married (___years). Widowed. Separated. Divorced. # of Healthy Children____ # of Deceased Children _____

Live with: Spouse. Family. Nursing Home. Assisted Living. Alone. Other_____

Tobacco Use: Smoker. Smokes ____Packs A Day. Smokeless Tobacco. Non-Smoker. Quit ____ Years Ago. Smoked ____ years.

Illicit Drug use.

Exercise includes: None. Walking Every Day. Walking Occasionally. Jogging. Aerobic Activity ___ Times Per Week. Treadmill. Weight Lifting. Other_____

Caffeine: YES____ NO____ Alcohol: YES____ NO____ If Yes, Daily or Occasionally.

Do you follow any special diet: YES____ NO____ If Yes, Why_____

Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.

Height____ft _____in. Weight_____lbs. Shoe Size_____

Current Medications and Doses (If Known) Pharmacy_____

1_____ 4_____ 7_____

2_____ 5_____ 8_____

3_____ 6_____ 9_____

Allergic To (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Other_____