# NEW PATIENT HISTORY FORM

**NAME** **DATE**

## Personal Health History

**Are you diabetic?** YES NO **Diabetic Physician:**_____

**What Type of Diabetes Do You Have?** **How long have you had diabetes?**

**Do You Have Hepatitis?** YES NO **Attending Physician:**_____

**Are You HIV Positive?** YES NO **Attending Physician:**_____

**Do You Take Coumadin?** YES NO **Attending Physician:**_____

**Do You Smoke?** YES NO **If Yes - How many packs a day?** _____ **If No - NEVER or QUIT Smoking**

**Are you interested in quitting smoking?** YES NO

**Do You Use Alcohol?** YES NO

**Do You Use Recreational Drugs?** YES NO

## ALLERGIES

***Please list all allergies - Include the type of reaction you have to the allergy***

| Name | Reaction You Had |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**ARE YOU ALLERGIC TO LATEX?** YES NO **TAPE?** YES NO

## *MEDICATIONS:* *(if you have a list we can copy it for you)- Please list over the counter drugs also*

| DRUG NAME | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## FAMILY HISTORY

**Please indicate any family history in the following areas - also indicate the family member**

| Condition | Mark if Yes | Family Members |
|---|---|---|
| DIABETES | | |
| CANCER | | |
| HEART CONDITIONS | | |
| HIGH BLOOD PRESSURE | | |

## CHIEF COMPLAINT

***Please indicate the reason for your visit today:( include all complaints)***

**Have You Seen A Podiatrist Before? YES NO Date of Last visit:**

**Activites You Particpate In:**

## EXERCISE

| | |
|---|---|
| | **Sedentary ( No Exercise)** |
| | **Mild (ie; climb staris, walk 3 blocks, golf** |
| | **Occasional Vigorous Exercise: ie; work or recreation less than 4x/ week for 30 minutes** |
| | **Regular Vigourous Exercise: ie, work or recreation 4x/ week for 30 minutes** |

**Are You Dieting? YES NO**

**If Yes are you under a physican medical diet plan? YES NO**

## Diagnosed Medical Problems

| | | |
|---|---|---|
| AIDS / HIV | Diabetes | Kidney Disease |
| Alcoholism | Depression | Multiple Sclerosis |
| Anemia | Diverticulosis | Polio |
| Anorexia/ Bulemia | Drug Dependency | Psoriasis |
| Arthritis | Gout | Phychiatric Care |
| Asthma | Hay Fever/ Allergies | Rheumatic Fever |
| Bleeding Disorders | Heart Disease | Stroke |
| Blood Transfusions | Hepatitis | Ulcers |
| Cancer | High Blood Pressure | Other Illnesses: |
| Congenital Disorders | | |

## PODIATRY HISTORY

**Circle if you have or have had any of the following areas to a significant degree**

| | | |
|---|---|---|
| Heel Pain / Arch Pain | Painful Corns | Recent Changes in Weig |
| Bunion Pain | Warts | Shooting Pain in Feet / l |
| Flat Feet | Rash on Foot | Ingrown Toenail |
| Numbness or Tingling In Feet | Itching of Feet | Gout |
| Trauma or Injury | Hammertoes | Other: |
| Ankle Pain | Circlation Problems | |

## PAST SURGERIES

***Please List Any Surgeries and or Complications in the past 5 years***

**SURGERY**

| Year | Reason | Complication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Have you ever had a blood transfusion?** **YES** **NO**

**PLEASE PROVIDE US WITH YOUR CURRENT**

**HEIGHT** _____ ***WEIGHT*** _____ **SHOE SIZE** _____

## MEDICAL HISTORY (Please Circle)

**Constitutional**
Weight Loss
Fever
Chills
Weakness
Fatigue
Anxiety

**Respritory**
Shortness of Breath
Cough
Sputum

**Cardiovascular**
Chest Pain
Chest Pressure
Swelling Feet/ Ankles
Palpitations
Edema
Cold Feet

**Skin**
Rash
Itching
Sores not h

**Gastrointestinal**
Anerexia
Nausea
Vomitting
Diahrrea
Abdominal Pain

**Genitourinary**
Burning on Uriation
Frequent Unrination

**Musculskeletal**
Joint Stiffness
Joint Swelling
Pain in Walking
Muscle Pain

**Endocrinol**
Sweating
Cold Intoler
Heat Intoler
Excessive Th
Polyuria
Polydipsia

**HEENT/ EYES**
Visual Changes
Blurred Vision
Double Vision

**Ears/ Nose. Throat**
Hearing Loss
Sneezing
Congestion
Runny Nose
Sore Throat

**Hematologic**
Anemia
Bruising
Bleeding

**Neurological**
Headache
Dizziness
Numbness of Extremitie
Tingling of Extremities
Paralysis
Ataxia

**Treatment Consent**

I hereby give consent and permission for the doctor to treat me for the above conditions. He will inform me and include me in any decsions regarding the treatment of my feet, ankles and lower legs. To the best of my knowledge the above information is true and correct. I understand it is my responsibility to inform my doctor

if I, or my minor child, ever have a change in health.

***Signature of Patient, Parent, or Guardian*** _____ Date_____

ency Taken

Weight
et / legs

ot healing

**rinologic**

tolerance
tolerance
ve Thirst

mities