PRO MEDICAL
PODIATRY

PODIATRY/ORTHOPEDICS
MEDICAL HISTORY

TODAY'S DATE: _____

PATIENT INFORMATION

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____ **Weight:** _____ **Height:** _____ **Shoe Size:** _____

Allergies: ☐ None ☐ Latex ☐ Adhesive ☐ Medication: _____ ☐ Other: _____

Serious Injuries/Illnesses/Medical Concerns: _____

Hospitalizations or Surgeries: _____

MEDICATION INFORMATION

Prescription Medications/Supplements: ☐ NONE

MEDICATION	DOSAGE

Preferred Pharmacy: _____

FAMILY HISTORY

Is there family history of one of the following?

If yes, please explain the condition and relative:

Arthritis	☐ No	☐ Yes	☐ Unknown	_____
Heart Disease	☐ No	☐ Yes	☐ Unknown	_____
Diabetes	☐ No	☐ Yes	☐ Unknown	_____
Cancer	☐ No	☐ Yes	☐ Unknown	_____

LIFESTYLE FACTORS

Alcohol	☐ No	☐ Yes	*If yes, how often?*	_____
Caffeine	☐ No	☐ Yes	*If yes, how often?*	_____
Recreational Drugs	☐ No	☐ Yes	*If yes, how often?*	_____
Tobacco	☐ No	☐ Yes	*If yes, how many packs/day?*	_____

PRO MEDICAL
PODIATRY

PODIATRY/ORTHOPEDICS
MEDICAL HISTORY

PATIENT'S PRINTED NAME: _____

MEDICAL HISTORY

☐ AIDS/HIV/Venereal Disease	☐ Cancer	☐ Hepatitis or Liver Disease	☐ Respiratory Disease
☐ Anemia	☐ Chemical Dependency	☐ High Blood Pressure	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Kidney Problems	☐ Stroke
☐ Bladder Infection	☐ Glaucoma	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gout	☐ Prostate Problems	☐ Ulcers
☐ Blood Clots	☐ Heart Disease	☐ Psychiatric Care	☐ **None**

REVIEW OF CURRENT SYMPTOMS *(CHECK ALL THAT APPLY)*

☐ **NONE**

GENERAL	☐ Fever	☐ Chills	☐ Weight Loss	☐ Weight Gain
EYES	☐ Blurred Vision	☐ Double Vision	☐ Poor Vision	☐ Glasses
EARS / NOSE / THROAT	☐ Ringing in Ears	☐ Sinus Congestion	☐ Hearing Loss	☐ Sore Throat
HEART	☐ Chest Pain	☐ Irregular Heart Beat	☐ Palpations	
LUNGS	☐ Cough	☐ Shortness of Breath	☐ Difficulty Breathing	
INTESTINAL	☐ Upset Stomach	☐ Bloody Stools	☐ Constipation	☐ Diarrhea
URINARY	☐ Burning	☐ Frequent Urination	☐ Incontinence	
MUSCULOSKELETAL	☐ Joint Pain	☐ Muscle Weakness	☐ Joint Stiffness	☐ Swelling
SKIN	☐ Rashes	☐ Sores	☐ Masses	☐ Scars
NEUROLOGICAL	☐ Tremors	☐ Numbness	☐ Poor Balance	☐ Dizziness
PSYCHIATRIC	☐ Depression	☐ Mood Swings	☐ Anxiety	
ENDOCRINE	☐ Hair Loss	☐ Excessive Thirst	☐ Fatigue	☐ Diabetes
BLOOD / LYMPHATIC	☐ Leg Swelling	☐ Bleeding Tendency	☐ Bruise Easily	☐ Anemia
OB/GYN	☐ Pregnant	☐ Birth Control Pills	☐ Hormone Therapy	☐ Menopausal

Other Symptoms or Concerns *(not listed above)*: _____

Duration of Symptoms *(this episode)*: _____

What makes the symptoms better? _____ **Worse?** _____

SIGNATURES

Patient *(Age 18 or older)*: _____ **Date:** _____

Parent/Guardian *(If patient is under age 18)*: _____ **Date:** _____

Provider: _____ **Date:** _____