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PATIENT HISTORY FORM

Name: ____ Date: _________________

SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)
1) ____
2) ____
3) ____
4) ____

ALLERGIES: (aspirin, sub drugs, penicillin, Iodine, Novocain, tape, foods, drugs, etc Describe Reaction________________
1) __________________________________ 3) __________________________________
2) __________________________________ 4) __________________________________

Have you ever had a reaction to local or general anesthesia? __ Yes __ No Describe ______________________________

MEDICATIONS: (Please include dosage of each. Include vitamins and supplements). ☐ See attached list
1) ________________________ 4) ________________________ 7) ________________________
2) ________________________ 5) ________________________ 8) ________________________
3) ________________________ 6) ________________________ 9) ________________________

SOCIAL HISTORY:
Occupation: ____
Do you spend most of your time standing, walking, heavy lifting, etc.____?
Disabled: ____________ Retired: _______________ Sports and Exercise: ____________________ hrs/wk
Tobacco: __ No __ Yes Packs per Day_________? Alcohol: __ No __ Yes Drink per Day_______________?
Caffeine: __ No __ Yes How much & what kind? Illicit drugs: __ No __ Yes How much & what kind?
____ ____

FAMILY HISTORY:
List medical problems your parents have/had such as high blood pressure, diabetes, cancer, flatfeet, hammertoe, poor circulation, etc.
Mother __ Alive __ Deceased: ____
Father __ Alive __ Deceased: ____

Review of Systems: Please check all the apply to you

1. *Constitutional Systems:*
   - ☐ Dizziness
   - ☐ Faintness
   - ☐ Fever
   - ☐ Sleep Problems

2. *Eyes:*
   - ☐ Cataracts
   - ☐ Contacts/
   - ☐ Glasses
   - ☐ Dry Eyes
   - ☐ Excess Tearing
   - ☐ Glaucoma
   - ☐ Itchy Eyes

3. *Ear, Nose, Throat, Mouth:*
   - ☐ Hearing loss
   - ☐ Loss of Balance
   - ☐ Sore Throat
   - ☐ Sinus Problems

4. *Cardiovascular:*
   - ☐ Arm Pain
   - ☐ Chest Pain
   - ☐ Cold Feet
   - ☐ Calf Cramping
   - ☐ DVT/Blood Clot
   - ☐ Foot/Ankle Swelling
   - ☐ Leg Swelling
   - ☐ Heart Problems
   - ☐ High Blood Pressure
   - ☐ Palpitations
   - ☐ Pain in leg when walking
   - ☐ Pain in leg/foot at night
   - ☐ PVD
   - ☐ Rapid Hear Beat
   - ☐ Varicose Veins

5. *Respiratory:*
   - ☐ Asthma
   - ☐ Cough
   - ☐ COPD
   - ☐ Difficulty Breathing
   - ☐ Shortness of Breath
   - ☐ Smoker yrs ____

6. *Gastrointestinal:*
   - ☐ Abdominal Pain
   - ☐ Blood in Stool
   - ☐ Heartburn
   - ☐ Liver Problems
   - ☐ Nausea
   - ☐ Reflux

7. *Genitourinary*
   - ☐ Currently Pregnant
   - ☐ Enlarged Prostate
   - ☐ On Dialysis
   - ☐ Painful Urination

8. *Musculoskeletal*
   - ☐ Amputation
   - ☐ Arthritis
   - ☐ Back Pain
   - ☐ Foot Pain
   - ☐ Fractures
   - ☐ Gout
   - ☐ Heel Pain
   - ☐ Hip Pain
   - ☐ Joint Pain
   - ☐ Joint Swelling
   - ☐ Muscle Pain
   - ☐ Osteoporosis
   - ☐ Previous Foot Problems
   - ☐ Sprains
   - ☐ Stiffness

9. *Integumentary:*
   - ☐ Athletes Feet
   - ☐ Cyst
   - ☐ Deformed Nail
   - ☐ Dry Scaly Skin
   - ☐ Discoloration

10. *Neurological:*
    - ☐ Abnormal Gait
    - ☐ Confusion
    - ☐ Dizziness
    - ☐ Headaches
    - ☐ Loss of Balance
    - ☐ Migraines
    - ☐ Numbness
    - ☐ Paralysis
    - ☐ Seizures
    - ☐ Stroke
    - ☐ Tingling
    - ☐ Weakness

11. *Psychiatric:*
    - ☐ Anxious
    - ☐ Alcoholism
    - ☐ Dementia
    - ☐ Depression
    - ☐ Drug Abuse

12. *Endocrine:*
    - ☐ Diabetes I (w Insulin) yrs.___
    - ☐ Diabetes II (w/out Insulin) yrs.___
    - ☐ Diet Controlled
    - ☐ On Oral Medication Bld Sgr.______ HGA1C ______
    - ☐ Hypothyroid (underactive)
    - ☐ Hyperthyroid (overactive)

Pharmacy

Ph____________________

Address________________ ☐

13. *Hematogic/Lymphatic*
    - ☐ Anemia
    - ☐ Ankle/Foot Edema
    - ☐ Bruise Easily
    - ☐ BleedingProblems
    - ☐ Hepatitis
    - ☐ HIV/Aids
    - ☐ On Blood Thinner

14. *Allergic/Immunologic:*
    - ☐ Latex Allergy
    - ☐ Medication Allergies

    Reaction______________
    - ☐ Seasonal Allergies

15. *Current Treating Physicians:*

PCP___________________
Phone: _________________
Cardiologist
____
Phone: _________________
Specialists
1.___________________
Phone: ________________
2.____________________
Phone: _______________

Reviewed by Robert W. Sullivan DPM _____________________