

## HEALTH HISTORY

*All information provided on this form will remain confidential in compliance with HIPAA guidelines.*

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

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### PODIATRIC HISTORY

Have you seen a Podiatrist before? YES  NO

If you answered YES, please complete the following information.

Doctor's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Condition for which you were treated \_\_\_\_\_

Describe the condition that brings you to our office today.

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Occupation \_\_\_\_\_

Athletic activities in which you participate (Please list the activities and indicate how often you participate.)

| <u>Activity</u> | <u>Frequency</u> |
|-----------------|------------------|
| _____           | _____            |
| _____           | _____            |

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### MEDICAL HISTORY

Please mark which problems you now have or have had in the past.

|                              |                              |                             |                          |                              |                             |
|------------------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| AIDS/HIV                     | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Hepatitis                | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Anemia                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> | High blood pressure      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Arthritis                    | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Hip/knee replacement     | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Artificial Heart Valve       | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Irregular heart beat     | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Bleeding disorder            | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Kidney disease           | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Blood clots in legs or lungs | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Asthma/Emphysema         | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Mitral Valve Prolapse        | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Musculoskeletal problems | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Diabetes                     | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Psychiatric disorders    | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Seizure or Stroke            | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Neuropathy               | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Gallstones                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Gout                     | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Stomach ulcers               | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Heart attack             | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Thyroid disorders            | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Heart murmur             | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Varicose veins               | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Heartburn                | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| High Cholesterol             | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Cancer                   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

Please list any surgeries you have had.

When?

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**SOCIAL HISTORY**

Alcohol                      YES     NO                       How much per week \_\_\_\_\_

Smoke                        YES     NO                       Packs per day \_\_\_\_\_

Are you now, or have you been under the care of a doctor other than your primary care doctor over the past two years?

YES     NO

If you answered YES, please explain.

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**MEDICATIONS**

Do you take oral contraceptives?    YES     NO

Do you take anticoagulant therapy?    YES     NO

Please list all medications you are currently taking –  
including over-the-counter medications and vitamins

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**ALLERGIES**

No allergies

- Adhesive tape                       Latex
- Aspirin                                       Local anesthetics
- Codeine                                       Novocaine
- Demerol                                       Penicillin
- Iodine                                         Seafood
- Sulfa drugs
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my podiatric condition(s).

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE