PREMIER MEDICAL
ASSOCIATES

PODIATRY

MEDICAL HISTORY

Patient Name: _____

DRUG ALLERGIES

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

❑ Hypertension_____
❑ Hyperlipidemia _____
❑ Heart palpitations _____
❑ Heart murmur _____
❑ Arrhythmia_____
❑ Chest pain/Angina _____
❑ MI _____
❑ Stroke / TIAs _____
❑ Claudication _____
❑ Congestive heart failure _____
❑ Congenital heart disease _____
❑ Headache _____
❑ Epilepsy _____

❑ Dizziness / Fainting_____
❑ Anxiety _____
❑ Fatigue _____
❑ Shortness of breath _____
❑ Orthopnea_____
❑ Allergies / Hay fever _____
❑ Asthma _____
❑ COPD _____
❑ Pneumonia _____
❑ Venereal disease_____
❑ Scarlet fever _____
❑ Rheumatic fever _____
❑ Liver disease_____

❑ Ulcer _____
❑ GI Disorder _____
❑ Sexual dysfunction _____
❑ Menstrual dysfunction_____
❑ Incontinence _____
❑ Anemia _____
❑ Arthritis _____
❑ Osteoporosis_____
❑ Gout _____
❑ Diabetes _____
❑ Endocrine disease _____
❑ Other_____
❑ Other_____

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

HABITS

❑ Smoke Packs daily _____
How long? _____
Interested in stopping?_____
❑ Exercise routine _____
_____
_____

❑ Coffee Cups daily_____
Other caffeine _____
❑ Alcohol Type _____
Amount _____

B.P. _____
Age _____
Height _____
Weight_____
Shoe Size _____

Whom may we thank for referring you to us?_____

Family physician _____ Date of last visit _____ What reason _____

Please describe your foot problem _____

_____

Have you had any previous foot care or foot surgery?_____If yes, by whom? _____