Patient Medical History

Date: _____ **Patient Name:**

1) [Medical History]: Have you ever had...? Date of Birth: ____/____/____ Age: _____

Ht._____ ___Wt___ ____

	Yes	No	
Lung Disease			Explain:
Heart Disease			Explain:
Blood Disease			Explain:
Liver Disease			Explain:
Digestive Disease			Explain:
Kidney Disease			Explain:
Nervous System Disease			Explain:
Joint/Muscle Disease			Explain:
Circulation Disorders			Explain:
Endocrine/Hormone Disorders			Explain:
Psychiatric Disorders			Explain:
Current infectious disease?			Explain:
Other Illness not mentioned?			Explain:
Could you be pregnant?			Date of last menstrual period?

2)[Current Medical Status]: Do you currently have any of the following? (Please Circle)

Diabetes Asthma Epilepsy High Blood Pressure Hepatitis Cancer

Fainting Anemia Chest Pains Stomach Ulcers Bleeding Tendency

Explain: _____

3) [Allergies]: Please list any allergies that you may have, and the type of reaction?

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Are you Allergic to: Anesthetics Antibiotics Steroids Aspirin Sedative Narcotics

4) [Medications]: What drugs do you take regularly or have recently been prescribed?

Drug	Dosage	How Often	Medical Reason

5) [Surgeries]: List previous surgeries, dates and reason:

Surgery: _____ Date: _____ Reason: _____

Surgery: _____ Date: _____ Reason: _____

Surgery: _____ Date: _____ Reason: _____

6) [Family History]: Mother: _____ Father: _____

Are there any inheritable diseases in your family? _____

Any unusual causes of death in your family? _____

7) [Social History]: Tobacco: _____packs per day. Alcohol:_____drinks per week.

8) Do you have any current medical complaints or problems that are under investigation?

_____

_____

History of Patient's Podiatric Complaint

9) Describe any previous foot/ankle conditions, treatment and date of treatment.

_____

_____

Primary Care Physician's Name: _____ Date of last visit: _____

Previous Podiatrist's Name: _____ Date of last visit: _____

10) Please describe your current foot problem?:

_____

_____

For how long has this condition existed? _____Days _____Weeks _____Months _____Years

What caused your current foot problem? _____

I Hereby give Dr. Mark D. Dollard, DPM or his designate permission to examine and treat my feet:

Patient's Signature: _____ Date: _____

If minor, Guardian's Signature: _____ Date: _____