Medical History

Patient's Name ________________________________ **Date** ___________ **Birthday** _______________

Height ____________ Weight ____________ Age __________ Gender __________________

Name of Primary Doctor ___________________________________ **Date last seen** ________________

Name of Diabetic Doctor ___________________________________ **Date last seen** _______________

Chief Complaint (Nature of problem with location) ____
Onset: **Gradual** **Sudden**
Duration (days, weeks, etc.) ________________________
Progression: **Stable** **Improving** **Worsening**
Previous Medical Treatment
(Either self or other Doctor) ____
Do you have? (circle) **Rheumatoid Arthritis** **Arthritis** **Hepatitis: (A) (B) (C)** **Diabetes: Type I / Type II**
Decreased blood flow to feet **Decreased feeling in feet** **HIV/AIDS** **Cancer**

List other health problems: ____

Please list all medications: ____

Please list all allergies: ____
Have you ever smoked or chewed tobacco? **Yes/ No** **smoked or chewed (circle)** Do you still? **Yes/ No**
Do you drink alcohol? **Yes/ No / Social**
What surgeries or hospitalizations have you had in the past 5 years:

____
Date of last Flu injection _____________________Date of last Pneumonia injection _____________________
Date of last colonoscopy: ___________________ Date of last mammogram: _________________________
WOMEN: Is there any possibility you are pregnant? Yes/ No
FAMILY HEALTH: Have you or your family ever had the following?

CONDITION	SELF	MOTHER	FATHER	FAMILY
Heart Problems				
High Blood Pressure				
Kidney Problems				
Lung Problems				
Stomach/Bowel Problems				
Liver Problems				
Circulation Problems				
Epilepsy				
Arthritis				
Cancer				
Diabetes				
Bleeding Problems				

Physician who referred you to our office: __________________________________
If your physician did not refer you to us, how did you hear about our office?
( ) Friend (who may we thank?) ____ ( ) Internet
( ) Newspaper ( ) Phone Book ( ) Other: ______________________________________