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: _____