Medical History

Four States Foot Clinic
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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**

List surgies and/or hospitalizations and dates:
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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?) ____