Medical History

Four States Foot Clinic
Matthew B. Richins, DPM, DABPM

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, Hepatitis: (A) (B) (C), HIV/AIDS, Cancer, Decreased feeling in feet
Decreased blood flow (seen by Dr _____ for this problem, date seen _____)

List other health problems: _____

Please list all medications: _____

Please list all allergies: _____

Have you ever smoked, chewed tobacco or vaped? **Yes/ No smoked, chewed or vaped (circle)** Do you still? **Yes/ No**
Do you drink alcohol? **Yes/ No / Social**

List surgeries and/or hospitalizations and dates:
_____
Date of last Retinal Eye Exam or Eye Exam with dilation **(diabetic patients age 18-75) 2023 / 2024**

Have you ever been screened for HIV? **(patient ages 15-65)** _____ **(estimated year)**

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 type I or type II				
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?) _____