

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

Patient's Name: _____ **DOB** _____ **Date** _____

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) _____ (estimated year)

Have you ever been screened for HIV / (given blood)? Yes / No (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 _____