Eastern Shore Podiatry
MEDICAL HISTORY
INITIAL VISIT

Patient Name:_____ DATE:_____

Describe your foot problems and/or symptoms:

1.) _____

How long have you had this problem? _____Days Weeks Months

2.) _____

How long have you had this problem? _____Days Weeks Months

3.) _____

How long have you had this problem? _____Days Weeks Months

Describe any past problems with your feet or ankles:_____
_____
_____
_____

List any past surgical procedures on your feet or ankles and approximate dates:

1.) _____ Date:_____

2.) _____ Date:_____

3.) _____ Date:_____

Shoe size:_____Special shoes?_____Current weight:_____Height_____

Do you use? (Y or N) Walker:_____Crutches:____Cane:_____Wheel Chair:_____

Are you allergic or sensitive to:
Antibiotics: (Penicillin, Sulfa, etc.) Please list with reaction_____

_____

Anti-inflammatory medicines: (Motrin, Naprosyn, Aleve , etc). _____

_____

Other medicine allergies: _____

Any problems with local anesthetics (Novacaine, Lidocaine, etc.)? Y N

Describe Reaction: _____

Do you have or have you had any of the following conditions? Y or N

_____High Blood Pressure	_____Arthritis	_____Leg cramps
_____Heart Disease	_____Gout	_____Varicose veins
_____Poor Circulation	_____Bleeding disorder	_____Blood clots
_____Stomach ulcers	_____Anemia	_____Stroke
_____Kidney Disease	_____Skin Problems	_____Cancer
_____Toenail problems	_____Asthma	_____Seizures
_____Joint Replacement	_____Night Sweats	_____Cold Feet
_____Ankle/Foot Swelling	_____Foot Tingling	_____Lung Disease

Do you have Diabetes? Y N If yes, do you take insulin? Y N

When diagnosed_____ Treating physician: _____

Date of last treatment: _____

List any serious illness (last 10 years) _____
_____
_____
_____

List any major surgeries (last 10 years) _____
_____
_____
_____

Are you presently under a physician's care Y N If so, please list the condition being treated and the physician

Condition: _____ Physician:_____

Condition: _____ Physician:_____

Condition: _____ Physician:_____

What medications do you take regularly (include as needed and over-the-counter medications)?

Medication	Strength	Dosage

Social History:

Employment status FT PT Unemployed Retired

Do you smoke Y N If so, number of packs per day _____

Have you previously smoked Y N When did you quit? _____

How many packs? _____

Do you smoke cigars, pipes or use smokeless tobacco products? Y N

Do you exercise Y N If so, describe activities and frequencies

_____

Family History:

Mother Living_____Deceased_____Cause of death_____
Father Living_____Deceased_____Cause of death_____
Brother(s) Number_____How many living_____Causes of deaths_____

Sister(s) Number_____How many living_____Causes of deaths_____

Any family history of the following diseases?

Heart Disease	_____	Arthritis	_____
Cancer	_____	Bleeding disorder	_____
Diabetes	_____	Stroke	_____
Neurologic Disorder	_____	Circulation problems	_____
High Blood Pressure	_____	Vascular disorders	_____