NAME_____ DATE_____

PAST MEDICAL HISTORY

MEDICAL CONDITIONS: (**Please be sure to include all conditions for which you take medication**)

_____

_____

_____

_____

_____

ACCIDENTS/INJURIES: (**Be sure to include any foot injuries**)

_____

_____

_____

_____

SURGERIES & HOSPITALIZATIONS: (**Including the year**)

_____

_____

_____

_____

CURRENT MEDICATIONS (**Include vitamins & herbal supplements**):

_____

_____

_____

_____

_____

ALLERGIES TO MEDICATION:

____No known drug allergies

____Adhesive tape_____ ____Penicillin_____

____Aspirin_____ ____Sulfa_____

____Codeine_____ ____Other_____

____Latex_____ ____Other_____

ASSISTIVE DEVICES:

__Glasses __Contacts __Hearing Aids - ___Right, ___Left, ___Both

__Standard Cane __Brace __Corrective shoes - ___Right, ___Left, ___Both

__Quad cane __Walker __Wheelchair - ___ Electric, ___ Manual

__Crutches

ANY FAMILY HISTORY OF:

____ Cancer	____ Diabetes	____ Heart disease	____ High blood pressure
___Mother	___Mother	___Mother	___Mother
___Father	___Father	___Father	___Father
___Brother	___Brother	___Brother	___Brother
___Sister	___Sister	___Sister	___Sister
___Son	___Son	___Son	___Son
___Daughter	___Daughter	___Daughter	___Daughter

SOCIAL STATUS:

___Divorced ___Married ___Single ___Widowed ___ Separated ___ Student

Occupation _____ ___Student ___Disabled ___Retired ___Unemployed

Smoking: ___Never

___Current – Pack/s per day _____

___Former

Caffeine: ___ Yes ___No

Coffee: _____ cups per day.

Soda: _____ per day.

Tea: _____cups per day.

Alcohol: _____ drinks per day / week

Decaffeinated coffee: _____ cups per day.

PLEASE INDICATE IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

General constitution: __fatigue __fever __not feeling well

EYES: __none

__cataracts __focusing __glaucoma __macular degen __retinal problems

__corrective lenses

ENT: __none

__hearing loss __tinnitus __nasal symptoms __sinusitis __hoarseness

__difficulty or pain swallowing

CV: __none

__blood clots
__CAD (coronary artery disease)
__CHF (congestive heart failure)
__chest pain
__heart attack
__heart murmur
__high blood pressure
__mitral valve prolapse
__pacemaker
__palpitations
__phlebitis
__rheumatic fever
__swelling of feet / ankles
__valvular heart disease

RESP: __none

__asthma
__bronchitis
__shortness of breath
__cough
__emphysema
__pneumonia
__COPD (chronic obstructive pulmonary disease)
__tuberculosis

GI: __none

__constipation
__diarrhea
__hepatitis
__hiatal hernia
__indigestion
__liver problems
__nausea
__stomach ulcers
__vomiting

GU: __none

Women:
__chronic yeast infections
__possibility of pregnancy
__postmenopausal

Men:
__prostate problems

Both women and men:
__painful urination
__excessive urination
__blood in urine
__kidney disease
__frequent UTI's (urinary tract infections)

MUSCULO: __none

__arthritis
__cramping
__fibromyalgia
__history of fracture
__injury
__osteoporosis
__joint pain
__joint stiffness

SKIN: __none

__skin cancer
__dryness
__keloid (excessive scarring)
__psoriasis
__rash within the last 24 hours

NEURO: __none

__convulsions __paralysis __tremor

__migraines __Parkinson's disease __vertigo

__head injury __seizures

__numbness/tingling __stroke

PSYCH: __none

__increased anxiety __memory loss

__depression __ panic disorder

__insomnia __ bipolar disorder

__other psychiatric symptoms

ENDOCRINE: __none

__diabetes __hyperthyroidism (high) __impaired glucose tolerance

__hormone problems __hypothyroidism (low) __excessive thirst

HEMA/LYMPH: __none

__anemia __cholesterolemia (high cholesterol)

__anticoagulant __enlarged lymph nodes

__bleeding/bruising tendency __radiation treatment

__chemotherapy

ALLERGY/IMMUNOLOGY: ___ none

___ Skin rash/ hives ___ Hay fever

___ Anaphylaxis Other: _____

Please explain if you have any allergy/immunology conditions

How did you hear about us?

____ Newspaper

____ Letter

____ Website

____ Friend/Relative &Their Name: _____

____ Existing patient

Other (Please explain):_____

Patient Signature _____ Date_____

Reviewing Physician Signature _____ Date_____