MEDICAL HISTORY FORM

DATE: _______________

Reason forVisit____

Family Physician____

Medical History (check all that apply):

___Arthritis ___Gout ___Liver Disease/Hepatitis
___Asthma ___Healing/Abnormal Bleeding ___Lung Problems
___Blood Clots ___Heart Problems ___Neurological Disorders
___Circulation ___High Blood Pressure ___Psoriasis
___Depression ___High Cholesterol ___Skin Problems
___Diabetes ___HIV/AIDS ___Stomach/Intestine ___Depression
___Joint Replacements ___Thyroid (Hyper/Hypo)
___Fibromyalgia ___Kidney Problems (Stones, etc)
___Other____

Allergies (Food or Drugs)____

Medications:

____
____
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Past Surgeries/Hospitalizations (include dates)**:**

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Social History

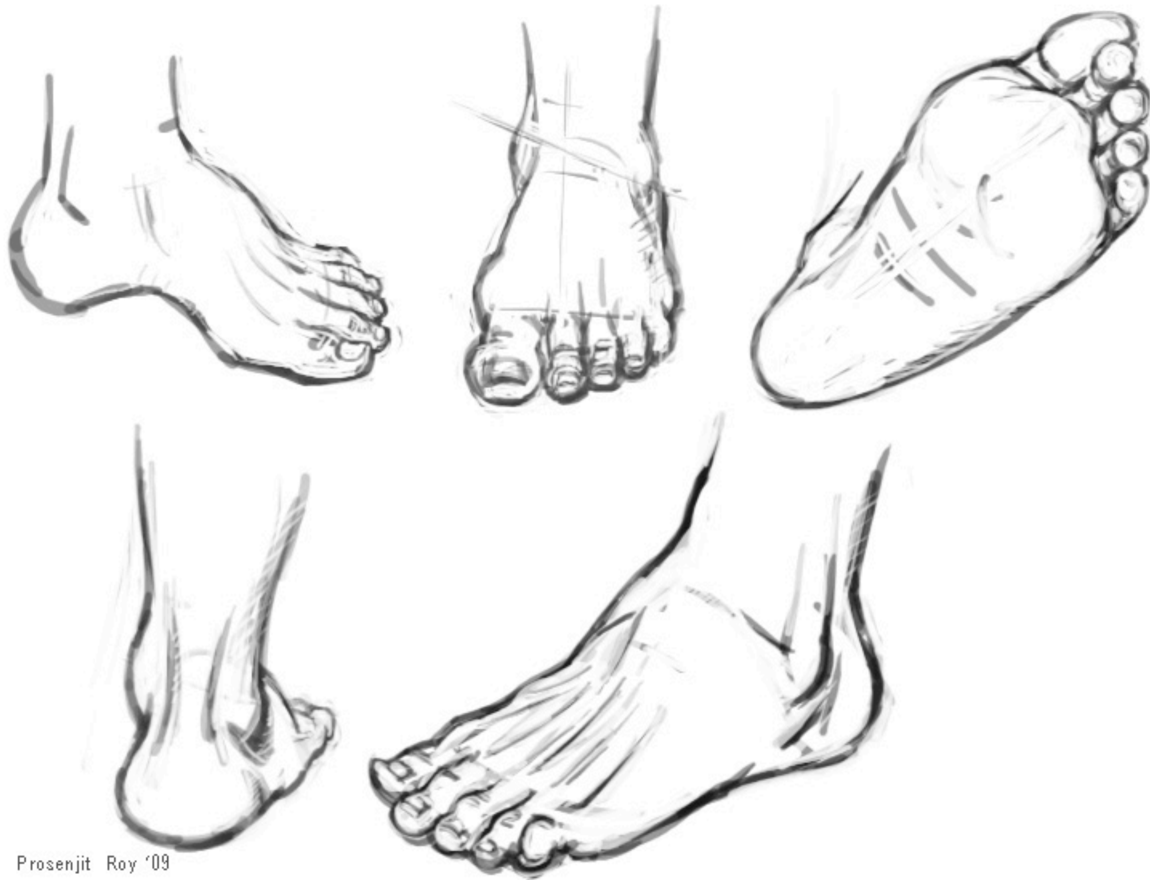
Do you drink alcohol? Yes No If yes, how much? _______________________
Do you smoke? Yes No If yes, how much? _______________________
Are you pregnant? Yes No If yes, when is your due date?_____________

Are you *currently* experiencing any of the following:	**Yes**	**No**	**If yes, please explain:**
General (Chronic fever, unexpected weight loss/gain, fatigue)	□	□	__________________
Eye (Double vision, glaucoma, vision loss, cataracts)	□	□	__________________
Ear/Nose/Throat (Hearing loss, sinus problems, dizziness)	□	□	__________________
Heart (Chest pains, irregular heartbeats, heart murmur)	□	□	__________________
Respiratory (Shortness of breath, wheezing, coughing)	□	□	__________________
Gastrointestinal (Heartburn, diarrhea, vomiting, abdomen pain)	□	□	__________________
Urinary (Frequent or painful urination, blood in urine)	□	□	__________________
Musculoskeletal (Muscle aches, arthritis, swollen joints, gout)	□	□	__________________
Skin (Rashes, excessive dryness, sores, itching)	□	□	__________________
Neurological (Numbness, weakness, headaches, paralysis)	□	□	__________________
Psychiatric (Depression, anxiety)	□	□	__________________
Endocrine (Thirst or sweating, thyroid problems)	□	□	__________________
Hematological/Lymphatic (Anemia, bleeding problems)	□	□	__________________

__________________________ _________________
Patient Signature Date

PLEASE NOTE WHICH FOOT: LEFT/RIGHT OR BILATERAL

(PLEASE MARK DIAGRAM):



REGARDING THE PLACE(S) YOU MARKED ABOVE, DESCRIBE THE PAIN YOU EXPERIENCE, FOR INSTANCE MILD, MODERATE, SEVERE, THROBBING, BURNING, ETC.:

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