

Medical History

Reason for today's visit: _____

How long has this been going on?: _____

Is this due to injury? NO ___ **IF YES, how?** _____

Age: _____

Male/Female

Weight: _____

Height: _____

Social History: Do you drink alcohol? YES ___ NO ___ Socially ___ If yes, how often ___

Do you smoke? YES ___ NO ___

Present Medication or provide a list: _____

Medical History: check if any of these apply to yourself or family member. If yes explain.

	<u>Patient</u>		<u>Family</u>			
	No	Yes		Type I	Type II	Age at onset:
Diabetes:	___	___	___	___	___	___
HIV/AIDS:	___	___	___			
Thyroid:	___	___	___	Eye Problems	NO ___ YES ___	
Asthma:	___	___	___	Name of Eye Condition:	_____	
Arthritis:	___	___	___	Last Eye Exam:	_____	
Liver:	___	___	___			
Heart Condition:	___	___	___			
Kidney:	___	___	___			
High B/P:	___	___	___			
Polio:	___	___	___			
Back/Hip Injury	___	___	___			
Seizure:	___	___	___			
Cancer:	___	___	___	Type	_____	
Hepatitis:	___	___	___	Type	_____	
Drug Allergies:	___	___	___	List:	_____	

Have you been previously treated by a Podiatrist? NO ___ YES ___ if yes, for what conditions? _____

Past Surgeries: _____

Pt Name:

Referring Physician: