Atlantic Foot Specialists PLLC Medical History

Name_____ Date_____

1. What is the reason for your visit today?_____

2. History of past illnesses: (check all that apply)

__Asthma	__High Blood Pressure	__Thyroid problem
__Diabetes(Type I / II)	__High cholesterol	__Tuberculosis
__Heart Attack	__Kidney problems	__Ulcer/Gastritis
__Heart failure	__Liver problem	__Cancer (site:_____)
__Heart valve problems	__Lung problems	

__Other (please list)_____

_____

3. Medications: _____

_____

4. Medication allergies: _____

5. Have you ever had any surgery: __Yes __No

__Appendectomy	__Hysterectomy
__Bypass (if so, what _____)	__Gallbladder
__Joint replacement (If so, what_____)	
__Other_____	

6. Social History: Occupation_____

Alcohol	__Yes	__No	(If yes) __< 1 per wk	__1-5 per wk	__Other_____
Tobacco	__Yes	__No	(If yes) __Smoke (#packs per wk_____)		__Smokeless

7. Family History: Check if your immediate family had any of the following:

__Arthritis	__Diabetes	__Heart Disease	__High blood pressure
__Cancer	__Gout	__Stroke	__Kidney Disease

8. Circle any symptoms you have had in the past year:

EYES-blurred vision, double vision or floaters **EARS**-ringing, hearing loss, **THROAT**-difficulty swallowing, hoarseness, **NOSE**-draining sinus, **CARDIOVASCULAR**-chest pain irregular heart beat palpitations, **RESPIRATORY**-shortness of breath asthma/wheezing persistent cough **GASTROINTESTINAL**- diarrhea constipation nausea, vomiting, **GENITOURINARY**- frequency urgency or pain with urination, **MUSCULOSKELETAL**- weakness/pain in joints **SKIN**-rash or bruise easily, **NEUROLOGICAL**-dizziness, tremors **PSYCHIATRIC** depression anxiety **LYMPHATIC** swelling of ankles phlebitis blood clots.

Primary Care Physician_____ Referring Source_____

Patient Signature_____ Date_____