Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
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PATIENT HEALTH INFORMATION

Name _____ Today's Date _____

When was your last physical examination? _____

Did you have an EKG? ☐ Y ☐ N A chest X-Ray? ☐ Y ☐ N What were the results? _____

HEALTH ISSUES

Please check the box next to any health conditions you have.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Breathing difficulty (explain _____)
- ☐ Heart trouble (explain _____)
- ☐ Hepatitis (explain _____)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid abnormality
- ☐ Blood circulation problems
- ☐ Varicose veins or blood clots
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Rheumatic Fever or Scarlet Fever
- ☐ Stomach or intestinal ulcers

Other major health issues: _____

SURGICAL HISTORY

List below all surgeries, broken bones, and traumatic injuries you have had.

Surgery/Injury	Approx. Date	Physician/Surgeon	Complications, if any

MEDICATIONS

List anything you are taking, including prescriptions, over-the-counter medications, and herbal/vitamin supplements.

Name	Prescribed by	For what condition?	Dose	Frequency

Name _____ Today's Date _____

ALLERGIES

List anything you are allergic to, including medications, environmental agents, food, etc.

☐ No allergies

Allergic to:	**Reaction**	**Allergic to:**	**Reaction**

SOCIAL HISTORY

☐ Y ☐ N Do you live alone?

☐ Y ☐ N Do you drink alcohol? If yes, how much? _____

☐ Y ☐ N Do you drink caffeine? If yes, how much? _____

☐ Y ☐ N Do you smoke? If yes, how much? If no, are you a former smoker? ☐ Y ☐ N

☐ Y ☐ N Do you use illicit drugs?

☐ Y ☐ N Do you have trouble sleeping?

☐ Y ☐ N Do you exercise regularly?

FAMILY HISTORY

Please indicate any major illnesses or health conditions affecting your immediate family members.