

DATE: _____ NAME: _____ AGE: _____

Please list the **names and doses** of **ALL** medications/vitamins/supplements you are currently taking:

Please list **allergies** you have to ANY medications, food, metal, latex, adhesive tape, etc:

Type of reaction _____

Type of reaction _____

Type of reaction _____

SOCIAL HISTORY

Do you smoke? _____ # packs per day _____ If you quit, how long ago? _____
Do you drink alcohol? _____ If yes, how often? _____ If you quit, how long ago? _____
Do you use illicit drugs? _____ If yes, what and how often? _____ If you quit, how long ago? _____
Do you have a walking/exercise routine? _____ How many times per week? _____
What is your occupation? _____

FAMILY HISTORY

Does/did anyone in your family have any of the following? If YES who?
Diabetes _____ Heart disease _____
Cancer (type) _____ Stroke/Blood clot _____

SURGICAL HISTORY

Please list ALL past **surgical procedures**: _____

REVIEW OF SYSTEMS: CIRCLE if you have you ever experienced problems with any of the following?

- | | | | |
|--|---|--|---|
| <u>HEENT</u>
Headaches
Vision problems
Dizziness
Ringing in ears
Nose bleeds
Difficulty swallowing | <u>RESPIRATORY</u>
Shortness of breath
Pneumonia | <u>HEMATOLOGIC/LYMPH</u>
Blood disorder
Lymph node disorder | <u>NEUROLOGICAL</u>
Neuromuscular problems
Neuropathy |
| <u>CARDIOVASCULAR</u>
Chest pain
Congestive heart failure | <u>GASTROINTESTINAL</u>
Acid Reflux
Stomach ulcers | <u>MUSKULOSKELETAL</u>
Joint pain
Muscle pain
Back pain/injury | <u>INTEGUMENTARY</u>
Melanoma
Eczema
Psoriasis |
| | <u>GENITOURINARY</u>
Bladder problems
Kidney problems | <u>ALLERGIC/IMMUNOLOGIC</u>
Seasonal allergies
Autoimmune disorder | |

*****What problem are you having with your foot today that brings you to the office?** _____
