MEDICAL HISTORY FORM

DATE: _____

Reason for Visit _____

Family Physician _____

Medical History (check all that apply):

_____ Arthritis	_____ Fibromyalgia	_____ Liver Disease/Hepatitis
_____ Asthma	_____ Gout	_____ Lung Problems
_____ Blood Clots	_____ Healing/Abnormal Bleeding	_____ Neurological Disorders
_____ Circulation	_____ Heart Problems	_____ Psoriasis
_____ Depression	_____ High Blood Pressure	_____ Skin Problems
_____ Diabetes	_____ High Cholesterol	_____ Stomach/Intestine
_____ Depression	_____ HIV/AIDS	_____ Thyroid (Hyper/Hypo)
_____ Joint Replacements	_____ Kidney Problems (Stones, etc)	

Other: _____

Allergies (Food or Drugs) _____

Medications:

_____

_____

_____

_____

Past Surgeries/Hospitalizations (include dates):

_____

_____

_____

_____

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
General (Chronic fever, unexpected weight loss/gain, fatigue)	☐	☐
If yes, please explain: _____		
Eye (Double vision, glaucoma, vision loss, cataracts)	☐	☐
If yes, please explain: _____		
Ear/Nose/Throat (Hearing loss, sinus problems, dizziness)	☐	☐
If yes, please explain: _____		
Heart (Chest pains, irregular heartbeats, heart murmur)	☐	☐
If yes, please explain: _____		
Respiratory (Shortness of breath, wheezing, coughing)	☐	☐
If yes, please explain: _____		
Gastrointestinal (Heartburn, diarrhea, vomiting, abdomen pain)	☐	☐
If yes, please explain: _____		
Urinary (Frequent or painful urination, blood in urine)	☐	☐
If yes, please explain: _____		
Musculoskeletal (Muscle aches, arthritis, swollen joints, gout)	☐	☐
If yes, please explain: _____		
Skin (Rashes, excessive dryness, sores, itching)	☐	☐
If yes, please explain: _____		
Neurological (Numbness, weakness, headaches, paralysis)	☐	☐
If yes, please explain: _____		
Psychiatric (Depression, anxiety)	☐	☐
If yes, please explain: _____		
Endocrine (Thirst or sweating, thyroid problems)	☐	☐
If yes, please explain: _____		
Hematological/Lymphatic (Anemia, bleeding problems)	☐	☐
If yes, please explain: _____		

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.: