PODIATRY MEDICAL HISTORY

Reed Luikaart, DPM
R Randal Aaranson, DPM

Name: _____ **DOB:** _____ **Age:** _____

Height: _____ **Weight**:_____ **Shoe Size:** _____

Pharmacy Name:_____ **Location:**_____

What are we seeing you for today? _____

Which foot or ankle: _____

Previous Treatment: _____

Circle all that apply in each category or circle normal if none apply.

CARDIOVASCULAR – Normal
Leg swelling Pacemaker Stents

INTEGUMENTARY – Normal
Skin Lesion

MUSCULOSKELETAL – Normal
Back Pain Neck Pain

NEUROLOGICAL – Normal
Numbness or tingling in extremities

Do you smoke? ☐Yes ☐No Number of pack(s) per day _____ How many years_____
Do you drink? ☐Yes ☐No Number of drinks per day _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT

Arthritis/Rheumatism ☐Yes ☐No
Artificial Joints (hips, knee, etc.) ☐Yes ☐No
Asthma/Lung Disorder ☐Yes ☐No
Bleeding Disorder/Tendency ☐Yes ☐No
Blood Clots ☐Yes ☐No
Cancer ☐Yes ☐No If yes where was the cancer? _____
Diabetes ☐Yes ☐No
Glaucoma ☐Yes ☐No
Gout ☐Yes ☐No
Heart (Surgery, Disease, Attack) ☐Yes ☐No
Heart Murmur ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
H.I.V. Positive ☐Yes ☐No
Joint/Back pain/Stiffness ☐Yes ☐No
Kidney Trouble ☐Yes ☐No
Liver Disease/Hepatitis ☐Yes ☐No
Neurological Disorder ☐Yes ☐No
Numbness In Feet/Legs ☐Yes ☐No
Peripheral Vascular Disease ☐Yes ☐No
Psychiatric/Psychological Care ☐Yes ☐No
Scarring Tendency ☐Yes ☐No
Stomach Problems/Reflux/Heartburn/Ulcers ☐Yes ☐No
Stroke ☐Yes ☐No
Swelling In Feet ☐Yes ☐No
Other _____

Are you allergic to latex? ☐Yes ☐No

ALLERGIES/MEDICATIONS/REACTIONS: ☐ **No medication allergies** **FOOD/REACTION:** ☐ **No food allergies**

_____

_____

History Reviewed by / Dr. Signature: _____Date: _____

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Patient Name:_____ **DOB:** _____

Family History Check all that apply.

❑ ADOPTED/UNKNOWN	Mother		Father		Brother or Sister
	☐ Alive	☐Deceased	☐ Alive	☐Deceased	
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Diabetes					
Asthma					
Seizures					
Bleeding Disorder					
Thyroid Disease					
Kidney Disease					
Mental Illness					

Medication	Dose	Surgery	Date

History Reviewed by / Dr. Signature: _____Date: _____