

BRIEF PATIENT HISTORY

Dr. _____

DATE _____

Please fill out completely

Patients full name:

Last _____ First _____ MI _____

Sex M F

Date of Birth _____

Please describe what brings you to the office today?

Name of Primary Care / Family Physician (first and last name) ?

Date last seen by Primary Care / Family Physician (month, day and year if known)

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI
insulin dependent diabetes non insulin dependent diabetes stroke/CVA aneurysm
blood clot

Past medical history – injuries/trauma

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy
fasciotomy

Please list approximate month and year of any surgery listed above:

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy
gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

Any other surgeries? (Please specify type of surgery and date)

Social History - Do you:

smoke tobacco

smoke marijuana

use hallucinogenic drugs

drink alcohol

use cocaine

use other recreational drugs

Alcohol, number of drinks

Number of drinks a day _____ greater than 5 per day _____ 1-3 drinks per week

4-6 drinks per week occasional use social drinking only week end drinking only

Social Smoker, number of packs per day

_____ number of pack per day 5 or more packs per day 1-2 packs per week 3-4 packs per week

Occasional smoking only social smoking only weekend smoking only

If you use other recreational drugs - please list/specify:

Medications - please list medications (including aspirin) currently taking:

Allergies - Do you have allergies to any of the following:

drug allergies

penicillin

sulfa

erythromycin

aspirin

cortisone

codeine

adhesive tape

local anesthetics

no known allergies

Other allergies to medications - please list:
