MORRIS PODIATRY ASSOCIATES, a Division of the NJPPSG

PATIENT MEDICAL HISTORY- PAGE 1

NAME: ____________________ **BIRTH DATE:** ____________ **TODAY'S DATE:** ____________

MEDICATIONS - LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBALSUPPLEMENTS). PLEASE IINCLUDE DOSAGE

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

ALLERGIES

[ ] Please check if you have NO KNOWN ALLERGIES

	Type of Reaction		Type of Reaction
[ ] Adhesive tape	__________	[ ] Latex	__________
[ ] Aspirin	__________	[ ] Novocaine/Anesthetics	__________
[ ] Codeine	__________	[ ] Penicillin	__________
[ ] Epinephrine	__________	[ ] Seasonal	__________
[ ] Food	__________	[ ] Sulfa	__________
[ ] Iodine/Seafood	__________	[ ] Other __________	__________

Are you currently pregnant? [ ] YES [ ] NO

CHECK ANY OF THE FOLLOWING YOU HAVE NOW OR IN THE PAST

[ ] Acid Reflux
[ ] Anemia
[ ] Angina
[ ] Arthritis
[ ] Artificial Heart Valves
[ ] Artificial Joints/Hardware
[ ] Asthma
[ ] Back Pain/Problems
[ ] Bladder Infections
[ ] Bleeding Disorders
[ ] Blood Clots/DVT
[ ] Blood Transfusions
[ ] Cancer
[ ] Cerebral Palsy
[ ] Chemical Dependency
[ ] Diabetes
[ ] Emphysema/COPD
[ ] Epilepsy/Seizures
[ ] Fainting/Low Blood Pressure
[ ] Fibromyalgia
[ ] Gout
[ ] Heart Attack
[ ] Heart Disease/Murmurs
[ ] Hepatitis
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV+/AIDS
[ ] Kidney Disease/Dialysis
[ ] Liver Disease
[ ] Migraines
[ ] Mitral Valve Prolapse
[ ] Multiple Sclerosis
[ ] Nervous Problems/Anxiety
[ ] Neuropathy
[ ] Pacemaker
[ ] Paralysis
[ ] Parkinson's disease
[ ] Peripheral Vascular Disease
[ ] Polio
[ ] Psychiatric Care/Disorder
[ ] Reflex Sympathetic Dystrophy
[ ] Rheumatic Fever
[ ] Rheumatoid Arthritis
[ ] Sickle Cell Disease
[ ] Stomach Ulcers
[ ] Stroke
[ ] Thyroid Disease
[ ] Tuberculosis
[ ] Venereal Disease

OTHER______________________________

SOCIAL HISTORY

Smoking Status [ ] Never smoked [ ] Former Smoker [ ] Current Smoker Amount/day? ______Yrs? ______
[ ] Cigarettes [ ] Cigars [ ] Marijuana
Do you drink Alcohol? [ ] Yes [ ] No If yes, is it infrequent, social, weekly, daily? (Please circle)
[ ] Beer [ ] Wine [ ] Hard Liquor [ ] Other
Do you/have you used Drugs? [ ] Yes [ ] No If yes, please describe______________________________

PLEASE LIST ALL PRIOR SURGERIES

Type of Surgery	Date	Type of Surgery	Date
__________	__________	__________	__________
__________	__________	__________	__________

MORRIS PODIATRY ASSOCIATES, a Division of the NJPPSG

PATIENT MEDICAL HISTORY- PAGE 2

PATIENT NAME_______________________________ **TODAY'S DATE** ______________________

BIRTH DATE________________________

REVIEW OF SYSTEMS **CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING**

1. Constitutional/General

General good health lately	[ ] Yes	[ ] No
Fever/Chills	[ ] Yes	[ ] No
Dizziness	[ ] Yes	[ ] No
Headaches	[ ] Yes	[ ] No

2. Eyes, Ears, Nose, Throat

Vision Problems/Glasses	[ ] Yes	[ ] No
Hearing Problems/Hearing Aids	[ ] Yes	[ ] No
Nasal Congestion	[ ] Yes	[ ] No
Dental difficulties/Dentures	[ ] Yes	[ ] No
Neck stiffness/Pain	[ ] Yes	[ ] No

3. Cardiovascular

Chest Pain/Heart Attack	[ ] Yes	[ ] No
History of Congestive Heart Failure	[ ] Yes	[ ] No
History of Heart Surgery	[ ] Yes	[ ] No
High Blood Pressure	[ ] Yes	[ ] No
Palpitations/Fainting	[ ] Yes	[ ] No
Stroke	[ ] Yes	[ ] No
Blood Clots/DVT	[ ] Yes	[ ] No

4. Respiratory

Shortness of Breath	[ ] Yes	[ ] No
Cough	[ ] Yes	[ ] No
Sleep Apnea/Snoring	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No
COPD/Emphysema	[ ] Yes	[ ] No
Fever or night sweats	[ ] Yes	[ ] No
Tuberculosis	[ ] Yes	[ ] No

5. Gastrointestinal

History of Ulcers	[ ] Yes	[ ] No
History of Heartburn	[ ] Yes	[ ] No
Nausea	[ ] Yes	[ ] No
Vomiting	[ ] Yes	[ ] No
Constipation or Diarrhea	[ ] Yes	[ ] No
Blood in Stool	[ ] Yes	[ ] No

6. Genitourinary

Painful Urination	[ ] Yes	[ ] No
Frequent Urination or Incontinence	[ ] Yes	[ ] No
Kidney Disease/Hemodialysis	[ ] Yes	[ ] No
Sexually Transmitted Disease	[ ] Yes	[ ] No

7. Musculoskeletal

Joint Pain	[ ] Yes	[ ] No
Joint Swelling	[ ] Yes	[ ] No
Joint Redness	[ ] Yes	[ ] No
Muscle Pain	[ ] Yes	[ ] No
Muscle Weakness	[ ] Yes	[ ] No
Muscle Cramps	[ ] Yes	[ ] No
Limitation of Motion	[ ] Yes	[ ] No

8. Skin

Rash	[ ] Yes	[ ] No
Itching	[ ] Yes	[ ] No
Eczema	[ ] Yes	[ ] No
Psoriasis	[ ] Yes	[ ] No
Dermatitis	[ ] Yes	[ ] No

9. Neurologic

Seizure Disorder	[ ] Yes	[ ] No
Numbness/Tingling	[ ] Yes	[ ] No
Hypersensitivity	[ ] Yes	[ ] No
Paralysis	[ ] Yes	[ ] No

10. Psychiatric

Anxiety	[ ] Yes	[ ] No
Depression	[ ] Yes	[ ] No
Addiction	[ ] Yes	[ ] No
Psychiatric Care	[ ] Yes	[ ] No

11. Endocrine

Thyroid Problems	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No
Unexplained Weight Loss	[ ] Yes	[ ] No
Unusual Fatigue	[ ] Yes	[ ] No

12. Hematologic/Lymphatic

Anemia	[ ] Yes	[ ] No
Tendency to Bleed	[ ] Yes	[ ] No
Bloating	[ ] Yes	[ ] No
Swollen lymph glands	[ ] Yes	[ ] No
Bruise easily	[ ] Yes	[ ] No
Cancer/type___________	[ ] Yes	[ ] No

13. Allergic/Immunologic

Gout	[ ] Yes	[ ] No
Reactions to drugs, food	[ ] Yes	[ ] No
Seasonal allergies	[ ] Yes	[ ] No

FAMILY HISTORY

Cancer	[ ] Yes	[ ] No	High Blood Pressure	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Rheumatoid Arthritis	[ ] Yes	[ ] No
Gout	[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No
Heart Disease	[ ] Yes	[ ] No	Thyroid Disease	[ ] Yes	[ ] No

WHAT IS YOUR SHOE SIZE ________________

VITALS

Height___________ Weight___________ Blood Pressure______________