NOLA Sole PODIATRY

Medical History

Name: _____

Date of Birth: _____

Preferred Pharmacy: _____

Pharmacy City/State _____

Family Physician: _____

Office #:_____

In your own words what is the reason for today's visit,

how long have you had this problem? _____

_____

Are you pregnant? ☐ No ☐ Yes

If yes, how many weeks? _____

Do you smoke? ☐ No ☐ Yes

If yes, how often? _____

Drink alcohol? ☐ No ☐ Yes

If yes, how often? _____

Do you use illegal drugs? ☐ No ☐ Yes

If yes, which ones? _____

Have you had any operations or serious injuries?

☐ No ☐ Yes if yes, please list below:

_____

_____

_____

Current Medications: _____

_____

_____

_____

Language Preferred: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐Non- Hispanic ☐ Hispanic ☐ Not Specified

Race: ☐ African or African American

☐Asian or Asian American

☐Caucasian or European American

☐Native American or Native Alaskan

☐Native Hawaiian or other Pacific Islander

☐Other Race

Allergies: ☐ No Known Drug Allergies ☐ Yes

If yes please list drug allergy and the reaction caused by it:

_____

_____

Please indicate by checking Yes or No for all those that apply to your health history:

Anemia	Yes	No	Hypertension	Yes	No	Stomach Ulcers	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No	Thyroid Disease	Yes	No
Asthma	Yes	No	Liver Problems	Yes	No	Tuberculosis	Yes	No
Bleeding Problems	Yes	No	Nervous Condition	Yes	No	Vision Trouble	Yes	No
Cancer	Yes	No	Phlebitis	Yes	No	Numbness in feet/legs	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No	Pain in feet/legs at night	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No	Pain in feet/legs walking	Yes	No
Gout	Yes	No	Skin Problems	Yes	No	Poor Circulation	Yes	No
Heart Problems	Yes	No	STDs	Yes	No	Peripheral Vascular Disease	Yes	No
HIV/ AIDS	Yes	No	Stroke/TIA	Yes	No	Hepatitis	Yes	No

Family History: Please inform us of the health of your family members as best you can. Indicate if any have had: Foot/Ankle Pain, Cancer, Heart Trouble, Kidney Disease, Stroke/TIA, Diabetes, Hypertension, and Arthritis

Mother: _____

Father: _____

Siblings: _____

Children: _____

Height: _____ feet_____inches

Weight: _____ lbs

Shoe Size: _____

If Diabetic Most Recent A1C/ Blood Glucose Level: _____

Email Address: _____

_____

Patient's Signature Date