MEDICAL RECORD

❖ 1 - General Patient Information

PATIENTS FULL NAME *(Last, First, M)*	DATE	BIRTH DATE	HEIGHT	WEIGHT

ADDRESS	SHOE SIZE

❖ 2 - Patient's Medical History

— MEDICAL CONDITIONS: PAST AND PRESENT —

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Anxiety
- ☐ Arthritis (OA, RA)
- ☐ Asthma
- ☐ Back, Hip, Knee Pain
- ☐ Broken Bone(s)
- ☐ CAD (Cholesterol)
- ☐ Cancer
- ☐ Cataracts
- ☐ Chron's / Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes ( )
- ☐ Diverticulosis
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis (A, B, C, D, E)
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Keloid / Thick Scar
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Ling Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Macular Degeneration
- ☐ Meniere's Disease
- ☐ Multiple Sclerosis
- ☐ Nerve Disorder (RSD)
- ☐ Numbness (Neuropathy)
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Poor Circulation (PVD)
- ☐ Psoriasis / Eczema
- ☐ Psychiatric Disorder
- ☐ Raynaud's Disease
- ☐ Reflux (GERD)
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sciatica
- ☐ Scleroderma
- ☐ Sickle Cell
- ☐ Sinusitis
- ☐ Sjogrens
- ☐ Spina Bifida
- ☐ Stomach Ulcer
- ☐ Stroke ( )
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcer (Skin)
- ☐ Vascular Phlebitis (Clots)
- ☐ Warts

Childhood Diseases: ☐ Measles ☐ Mumps ☐ Chicken Pox

Do you have vascular grafts? ☐ Yes ☐ No

Do you have joint / bone implants / screws? ☐ Yes ☐ No

Do you have replacement heart valves? ☐ Yes ☐ No

Have you had transfusions? ☐ Yes ☐ No

Number of your childbirths _____ Are you pregnant now? ☐ Yes ☐ No

Any other medical conditions not listed above

____

____

Surgery	Date	Complications	Surgery	Date	Complications

Primary Care Physician ______________________ **Other Physician** ______________________

— MEDICATIONS —

Name	Dosage	Name	Dosage

— ALLERGIES —

Is there a history of skin reaction or other outward reaction or sickness following any injection or oral or topical administration of:

Check box that applies	Yes	No	*If yes, what happens?*
Penicillin	☐	☐	
Erythromycin, Biaxin, Z Pack	☐	☐	
Keflex, Ceftin, Ceclor	☐	☐	
Cipro/Levaquin	☐	☐	
Sulfa Drugs (Bactrim)	☐	☐	
Gentamicin	☐	☐	
Aspirin	☐	☐	
Emprin or Tylenol	☐	☐	
Advil, Aleve or Motrin	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	

Check box that applies	Yes	No	*If yes, what happens?*
Demerol	☐	☐	
Novocain	☐	☐	
Injectable Steroids (Cortisone)	☐	☐	
General/Spinal	☐	☐	
Adhesive Tape	☐	☐	
Shrimp/Shellfish	☐	☐	
Iodine or Merthiolate	☐	☐	
Latex	☐	☐	
Other Drugs / Medications	☐	☐	

Allergic to / Reaction ______________________

— PLEASE BE SURE TO ANSWER ALL REMAINING QUESTIONS ON THE REVERSE SIDE —

MEDICAL RECORD (continued)

— FAMILY HISTORY —

List family members who have had any of the following:

	Relationship	Maternal	Paternal
Diabetes	____________	☐	☐
Arthritis	____________	☐	☐
Stroke	____________	☐	☐
Cancer	____________	☐	☐
Kidney / Liver Disease	____________	☐	☐
Foot Problems	____________	☐	☐
Heart Attack	____________	☐	☐
High Blood Pressure	____________	☐	☐
Birth Defects	____________	☐	☐
Poor Circulation	____________	☐	☐

Father ☐ Alive ☐ Deceased

Mother ☐ Alive ☐ Deceased

Please include all medical conditions currently listed under Family History

— SOCIAL HISTORY —

Do you smoke now?	☐ Yes	☐ No	Packs per Day ________		Number of Years ________		
Did you ever smoke?	☐ Yes	☐ No	Packs per Day ________		Number of Years ________		
Caffeine / Coffee / Tea / Soda	☐ Yes	☐ No	Amount per Day ________				
Alcoholic Beverage Consumption?	☐ Yes	☐ No	*(Frequency, circle one)*	Rarely	Moderately	Daily	Quit
Recreational Drugs Use?	☐ Yes	☐ No	*(Frequency, circle one)*	Rarely	Moderately	Daily	Quit

If yes, what Kind? ____________________

Activities ____

____

____

Occupation / Employer ____

____

____

— REVIEW OF SYSTEMS —

Please check all that apply:

CONSTITUTIONAL: ☐ unexplained weight loss ☐ unexplained weight gain ☐ fever ☐ chills ☐ nausea ☐ vomiting ☐ fatigue ☐ night sweats ☐ loss appetite ☐ hunger thirst

HEENTM: ☐ glasses / contacts ☐ blurred / double vision ☐ retinopathy ☐ hard of hearing ☐ dizziness ☐ nose bleeds ☐ difficulty chewing / swallowing / speaking ☐ sore mouth ☐ sore throat ☐ dentures ☐ TMJ ☐ discharge / drainage ☐ dental implants

CV: ☐ atrial fib ☐ pacemaker ☐ MVP ☐ murmur / palpitations ☐ WPW ☐ CHF ☐ heart attack ☐ septal defec ☐ chest pain ☐ rapid beat

RESP: ☐ shortness of breath ☐ wheezing ☐ coughing ☐ cough blood ☐ on oxygen ☐ pneumonia / pleurisy ☐ bronchitis ☐ emphysema

GI: ☐ stomach / abdomen pain ☐ diarrhea ☐ constipation ☐ dark blood stool ☐ irritable bowel ☐ hemorrhoids

GU: ☐ frequent / painful / urination / bladder control ☐ kidney stones ☐ infection (UTI) ☐ blood urine ☐ nephropathy ☐ sex trans dis (STD) ☐ prostate

MSK: ☐ generalized aches and pains ☐ hammertoes ☐ bunions ☐ weakness ☐ back pain ☐ muscle cramps / walking ☐ muscle cramps / resting

INTRG: ☐ burns ☐ scars ☐ rashes ☐ corns / calluses ☐ ingrown nails ☐ painful nails ☐ open sores

NEURO / PSYCH: ☐ balance trouble ☐ difficulty sleeping ☐ confusion ☐ tremors ☐ numbness ☐ tingling ☐ fainting / blackouts ☐ brain disorder

HEMO / LYMPHATIC: ☐ bleeding problem ☐ swelling ☐ bruising ☐ clots ☐ varicose veins

VALLEY PODIATRY ASSOCIATES, P.C.

PATIENT SIGNATURE ________________________________ DATE ________________