MEDICAL RECORD

❖ 1 - General Patient Information

PATIENT'S FULL NAME (Last, First, M)	DATE	BIRTH DATE	HEIGHT	WEIGHT

ADDRESS	SHOE SIZE

❖ 2 - Patient's Medical History

– MEDICATIONS –

Name	Dosage	Name	Dosage

– MEDICAL CONDITIONS: PAST AND PRESENT –

☐ Alzheimer's	☐ Covid-19	☐ Headaches / Migraines	☐ Lyme Disease	☐ Psoriasis / Eczema	☐ Spina Bifida
☐ Anemia	☐ Crohn's / Colitis	☐ Heart Disease	☐ Macular Degeneration	☐ Psychiatric Disorder	☐ Stomach Ulcer
☐ Angina (Chest Pain)	☐ Dementia	☐ Hepatitis (A, B, C, D, E)	☐ Meniere's Disease	☐ Raynaud's Disease	☐ Stroke ( )
☐ Anxiety	☐ Depression	☐ Hiatal Hernia	☐ Multiple Sclerosis	☐ Reflux (GERD)	☐ Thyroid
☐ Arthritis (OA, RA)	☐ Diabetes ( )	☐ High Blood Pressure	☐ Nerve Disorder (RSD)	☐ Rheumatic Fever	☐ Tuberculosis
☐ Asthma	☐ Diverticulosis	☐ HIV	☐ Numbness (Neuropathy)	☐ Scarlet Fever	☐ Ulcer (Skin)
☐ Back, Hip, Knee Pain	☐ Epilepsy / Seizures	☐ Keloid / Thick Scar	☐ Osteoporosis	☐ Sciatica	☐ Vascular Phlebitis (Clots)
☐ Broken Bone(s)	☐ Fibromyalgia	☐ Kidney Disease	☐ Paralysis	☐ Scleroderma	☐ Warts
☐ CAD (Cholesterol)	☐ Gall Bladder	☐ Liver Disease	☐ Parkinson's Disease	☐ Sickle Cell	
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Polio	☐ Sinusitis	
☐ Cataracts	☐ Gout	☐ Lupus	☐ Poor Circulation (PVD)	☐ Sjogren's	

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** _____

– 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?*	*Check box that applies*	*Yes*	*No*	*If yes, what happens?*
Penicillin	☐	☐		Demerol	☐	☐	
Erythromycin, Biaxin, Z Pack	☐	☐		Novocain	☐	☐	
Keflex, Ceftin, Ceclor	☐	☐		Injectable Steroids (Cortisone)	☐	☐	
Cipro/Levaquin	☐	☐		General/Spinal	☐	☐	
Sulfa Drugs (Bactrim)	☐	☐		Adhesive Tape	☐	☐	
Gentamicin	☐	☐		Shrimp/Shellfish	☐	☐	
Aspirin	☐	☐		Iodine or Merthiolate	☐	☐	
Emprin or Tylenol	☐	☐		Latex	☐	☐	
Advil, Aleve or Motrin	☐	☐		Other Drugs / Medications	☐	☐	
Morphine	☐	☐		Allergic to / Reaction			
Codeine	☐	☐					

– PLEASE BE SURE TO ANSWER ALL REMAINING QUESTIONS ON REVERSE SIDE AND SIGN –

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 _____

Do you vape? ☐ Yes ☐ No Amount 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

PATIENT SIGNATURE _____ DATE _____

Valley Podiatry ASSOCIATES, PC