

**PREMIER PODIATRY GROUP  
PATIENT'S HEALTH HISTORY SHEET**

**PATIENT NAME:** \_\_\_\_\_

**PATIENT'S DATE OF BIRTH:** \_\_\_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**PREVIOUS XRAYS OR MRI'S: YES OR NO IF YES, WHERE & WHEN** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE:** \_\_\_\_\_

**MEDICATIONS TAKEN DAILY:** \_\_\_\_\_

**ALLERGIES TO MEDICATION & TYPE OF REACTION:** \_\_\_\_\_

**PAST MEDICAL HISTORY:** \_\_\_\_\_

**PAST SURGERIES:** \_\_\_\_\_

**DO YOU CURRENTLY OR HAVE YOU EVER USED TOBACCO PRODUCTS? \_\_YES \_\_NO \_\_PAST**

**DO YOU DRINK ALCOHOL: \_\_YES \_\_NO IF SO HOW OFTEN:** \_\_\_\_\_

**PLEASE CIRCLE YES OR NO IF YOU HAVE ANY OF THE FOLLOWING:**

<b>AIDS/HIV</b>	<b>YES NO</b>	<b>LIVER DISEASE</b>	<b>YES NO</b>
<b>ANEMIA</b>	<b>YES NO</b>	<b>NEUROPATHY</b>	<b>YES NO</b>
<b>ARTHRITIS</b>	<b>YES NO</b>	<b>PSYCHIATRIC CARE</b>	<b>YES NO</b>
<b>ARTIFICIAL HEART VALVE</b>	<b>YES NO</b>	<b>RASH</b>	<b>YES NO</b>
<b>ARTIFICIAL JOINT</b>	<b>YES NO</b>	<b>RESPIRATORY DISEASE</b>	<b>YES NO</b>
<b>ASTHMA</b>	<b>YES NO</b>	<b>SHORTNESS OF BREATH</b>	<b>YES NO</b>
<b>BACK PROBLEMS</b>	<b>YES NO</b>	<b>SINUS PROBLEMS</b>	<b>YES NO</b>
<b>BLEEDING DISORDER</b>	<b>YES NO</b>	<b>STOMACH ULCERS</b>	<b>YES NO</b>
<b>CANCER TYPE _____</b>	<b>YES NO</b>	<b>STROKE</b>	<b>YES NO</b>
<b>CHEST PAINS</b>	<b>YES NO</b>	<b>SEXUALLY TRANSMITTED DZ.</b>	<b>YES NO</b>
<b>CHRONIC DIARRHEA</b>	<b>YES NO</b>	<b>SWELLING IN ANKLES</b>	<b>YES NO</b>
<b>CIRCULATORY DISORDER</b>	<b>YES NO</b>	<b>TUBERCULOSIS</b>	<b>YES NO</b>
<b>DIABETES</b>	<b>YES NO</b>	<b>ULCERS ON LEGS/FEET</b>	<b>YES NO</b>
<b>EAR PROBLEMS</b>	<b>YES NO</b>	<b>UNEXPLAINED WEIGHT LOSS</b>	<b>YES NO</b>
<b>EPILEPSY</b>	<b>YES NO</b>	<b>VARICOSE VEINS</b>	<b>YES NO</b>
<b>EYE PROBLEMS</b>	<b>YES NO</b>		
<b>FAINTING</b>	<b>YES NO</b>	<b>OTHER _____</b>	
<b>HEPATITIS TYPE _____</b>	<b>YES NO</b>		
<b>FOOT OR LEG CRAMPS</b>	<b>YES NO</b>		
<b>GOUT</b>	<b>YES NO</b>	<b>DATE: _____</b>	
<b>HEADACHES</b>	<b>YES NO</b>		
<b>HEART DISEASE</b>	<b>YES NO</b>		
<b>HIGH BLOOD PRESSURE</b>	<b>YES NO</b>		