

**PREMIER PODIATRY GROUP P.C.**  
**Past Medical History Questionnaire**

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Please list any medical conditions you have: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies and what type of reaction: \_\_\_\_\_

Surgeries you have had: \_\_\_\_\_

Do you currently or have you ever used tobacco products?    YES    NO

Do you drink alcohol? YES    NO        If so, how often? \_\_\_\_\_

Circle "YES" or "NO" if you have had any of the following:

AIDS/HIV	YES	NO	Liver Disease	YES	NO
Anemia	YES	NO	Neuropathy	YES	NO
Arthritis	YES	NO	Psychiatric Care	YES	NO
Artificial heart valve	YES	NO	Rash	YES	NO
Artificial joint	YES	NO	Respiratory Disease	YES	NO
Asthma	YES	NO	Shortness of Breath	YES	NO
Back Problems	YES	NO	Sinus Problems	YES	NO
Bleeding Disorder	YES	NO	Stomach ulcers	YES	NO
Cancer	YES	NO	Stroke	YES	NO
Chest Pain	YES	NO	Sexually transmitted dz	YES	NO
Chronic Diarrhea	YES	NO	Swelling in ankles	YES	NO
Circulatory Disorder	YES	NO	Tuberculosis	YES	NO
Diabetes	YES	NO	Ulcers on legs/feet	YES	NO
Ear Problems	YES	NO	Unexplained weight loss	YES	NO
Epilepsy	YES	NO	Varicose Veins	YES	NO
Eye Problems	YES	NO			
Fainting	YES	NO			
Foot or leg cramps	YES	NO			
Gout	YES	NO			
Headaches	YES	NO			
Heart Disease	YES	NO			
Hepatitis	YES	NO			
High Blood Pressure	YES	NO			
Kidney Problems	YES	NO			