Patient Medical History

Patient Name_____Date of Birth_____

Have you ever been hospitalized for a serious illness? Yes No
If yes, please list _____

Have you ever had surgery? Yes No
If yes, please list _____

(Women) Are you or is there a chance you might be pregnant? Yes No

Do you have or have you ever had any of the following *(please circle all that apply)*:

Diabetes	Congestive Heart Failure	Stroke
High Blood Pressure	Angina/Heart Attack	Gout
Coronary Artery Disease	Heart Murmur/Valve Problem	High Cholesterol
Kidney Disease/Urinary Problems	Thyroid Condition/Goiter	Emphysema/Lung Disease
Cancer/Tumors	Arthritis/Rheumatism	HIV/AIDS
Hepatitis/Liver Disease	Ulcers/GI Problems	Epilepsy/Seizures
Skin Disease	Measles/Mumps/Chicken Pox	Rubella/Small Pox
Blood Disorders	Pneumonia/Bronchitis/Asthma	Depression/Anxiety
Bleeding Problems/Blood Clots	Scarlet/Rheumatic Fever	Nervous Condition/Stress
Vascular Disease	Glaucoma/Eye Disease	

*Any disease, condition or problem not listed?*_____

Have you ever had a severe/traumatic injury or broken bone(s)? Yes No
If yes, please list _____

Do you: currently/previously use tobacco? currently/previously drink alcohol?
If so, how much/how often? _____

Family history of illness (parent/grandparent/sibling)_____

_____

Name of Primary Care Physician and date of last visit_____

Have you seen a Podiatrist before? Yes No
If yes, what did he/she treat you for? _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my health, allergies or medications, I will inform the doctor at my next appointment.

_____ _____
Signature of Patient/Authorized Agent Date

For Office Staff Only:
Reviewed by Dr. Rhodes on _____

Updated on_____