

Wiener & Daniels, DPM, PA

Patient Medical History Form (*please note, this form is required every three (3) years*)

Patient Name: _____ Date of Birth: _____ Age: _____
 Height: _____ Weight: _____

Who is your Family Physician?		
Date of last visit:		
Did your family physician refer you to our office?		Yes or No
If no, who may we thank for referring you to our office?		
What Pharmacy do you use?		Name: _____ Located: _____ Phone #: _____ Fax #: _____
What is your shoe size?		
Employer:		
What is your current occupation?		
Medical Information: (Please list the following information)		
What foot problem(s) bring you to our office today?		
How long have you had this problem?		
Please list any treatment(s) you have had/tried for this problem:		
Current Medical Problems	Current Medications	Allergies
1.	1.	<input type="checkbox"/> Penicillin
2.	2.	<input type="checkbox"/> Sulfa Drugs
3.	3.	<input type="checkbox"/> Betadine/Iodine
4.	4.	<input type="checkbox"/> Aspirin
5.	5.	<input type="checkbox"/> Local/Topical anesthesia
6.	6.	<input type="checkbox"/> Codeine
7.	7.	<input type="checkbox"/> Foods: Type _____
8.	8.	<input type="checkbox"/> Latex / Tape
9.	9.	<input type="checkbox"/> Seasonal
10.	10.	<input type="checkbox"/> Other
<input type="checkbox"/> NONE	<input type="checkbox"/> NONE	<input type="checkbox"/> NONE

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Family History: Does anyone in your family have the following problems:	
<input type="checkbox"/> Diabetes Who: _____	<input type="checkbox"/> High Blood Pressure Who: _____
<input type="checkbox"/> Cancer Type: _____ Who: _____	<input type="checkbox"/> Stroke Who: _____
<input type="checkbox"/> Arthritis Who: _____	<input type="checkbox"/> Bleeding Problems Who: _____
<input type="checkbox"/> Other: _____ Who: _____	
<input type="checkbox"/> NONE	
Social History: Do you do any of the following:	
<input type="checkbox"/> Yes <input type="checkbox"/> No Smoke: For how long? _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Drink Alcohol: How Much? _____ How often? _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Use Illegal Drugs What type? _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Take Aspirin daily?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Take Blood Thinner daily? Type: _____	
What is the highest level of schooling you have completed? _____	
Surgical History: Please list the operations you have had in your lifetime:	
1. _____	Year/Age: _____
2. _____	Year/Age: _____
3. _____	Year/Age: _____
4. _____	Year/Age: _____
5. _____	Year/Age: _____

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Have you ever had any of the following medical problems? <input type="checkbox"/> NONE		
GENERAL	EYES	EARS, NOSE, MOUTH, THROAT
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Ear ringing
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Wear glasses	<input type="checkbox"/> Balance difficulties
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Seasonal allergies
		<input type="checkbox"/> Chewing/swallowing problems
		<input type="checkbox"/> Hoarseness/chronic sore throat
HEART	LUNGS	STOMACH
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Heart Valve problems	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Constant vomiting
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Constant thirst or hunger
<input type="checkbox"/> Hypertension		
ABDOMINAL	MUSCULOSKELETAL	SKIN
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Rashes
<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Moles
<input type="checkbox"/> Bloody Discharge	<input type="checkbox"/> Back pain	<input type="checkbox"/> Abnormal lesions
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Cancer Type: _____
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Gout	<input type="checkbox"/> Nail disorders
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Arm pain	
	<input type="checkbox"/> Shoulder pain	
NEUROLOGICAL	PSYCHOLOGICAL	ENDOCRINE
<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mini-stroke	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Abnormal walking	<input type="checkbox"/> Drug/Alcohol dependence	
BLEEDING		ALLERGIES
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Hepatitis (B or C)	<input type="checkbox"/> Drug allergies
<input type="checkbox"/> Blood Cancer	<input type="checkbox"/> Sexually Transmitted Disease (STD)	<input type="checkbox"/> Anesthesia

Physician Signature: _____ Date: _____