SCITUATE PODIATRY HISTORY AND PHYSICAL

NAME _____ VISIT DATE _____

DOB _____ AGE _____ M ___ F ___ HEIGHT _____ WEIGHT _____ BP _____

PRIMARY CARE PHYSICIAN _____ DATE OF LAST VISIT _____

REASON FOR TODAY'S VISIT _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES OR REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

MEDICATION	REACTION OR SIDE EFFECT

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the follow medical problems

DESCRIPTION	SELF	FAMILY	RELATION	DESCRIPTION	SELF	FAMILY	RELATION
Hearing Problems				High Cholesterol			
Drug/Alcohol problems				Hepatitis or liver problems			
Cancer: List Type				Thyroid disease			
				Arthritis			
Kidney stones/cysts/failure				Anemia/Blood disorder			
Heart Disease				Gallbladder			
Circulatory Problems				Epilepsy or Seizures			
High Blood Pressure				Migraines			
Stroke				Osteoporosis			
Asthma, emphysema				Mental Health Problem			
Ulcers/Digestive problems				Diabetes			
Gout				HIV/AIDS/STD's/Tuberculosis			

TOBACCO HISTORY No____ Yes____ Packs per day _____ How many years _____ Quit Date _____

SURGICAL HISTORY (Please list all prior operations and dates):

OPERATION	DATE	OPERATION	DATE