MEDICAL AND HEALTH HISTORY

Patient's Last Name	First	Middle

Primary Care Physician:	Date of Last Exam: / /
Reason for today's visit:	

Shoe Size:	Height:	Weight: lbs.

HEALTH HISTORY

❑ **I have no past or current health conditions.**

Have you been treated for any of the following conditions, either currently or in the past?

	No	Past	Currently		No	Past	Currently
Diabetes	❑	❑	❑	High Blood Pressure	❑	❑	❑
Thyroid Disease	❑	❑	❑	Heart Attack or Chest Pain	❑	❑	❑
Neuropathy	❑	❑	❑	Heart Murmur	❑	❑	❑
Stroke	❑	❑	❑	Irregular Heart Beat	❑	❑	❑
Cerebral Palsy	❑	❑	❑	Congestive Heart Failure (CHF)	❑	❑	❑
Multiple Sclerosis	❑	❑	❑	Peripheral Vascular Disease	❑	❑	❑
Polio	❑	❑	❑	Blood Clots (DVT)	❑	❑	❑
Seizures	❑	❑	❑	Varicose Veins	❑	❑	❑
Depression	❑	❑	❑	Leg Swelling	❑	❑	❑
Sciatica	❑	❑	❑	Hepatitis	❑	❑	❑
Back Injury or Pain	❑	❑	❑	Jaundice	❑	❑	❑
Osteoarthritis (OA)	❑	❑	❑	Kidney Disease	❑	❑	❑
DJD	❑	❑	❑	Acid Reflux (Heart Burn)	❑	❑	❑
Rheumatoid Arthritis (RA)	❑	❑	❑	Tuberculosis (TB)	❑	❑	❑
Gout	❑	❑	❑	COPD	❑	❑	❑
Skin Wounds or Ulcers	❑	❑	❑	Asthma	❑	❑	❑
Eczema	❑	❑	❑	Shortness of Breath	❑	❑	❑
Psoriasis	❑	❑	❑	Infectious Disease	❑	❑	❑
Cancer	❑	❑	❑	Anemia	❑	❑	❑

Other health conditions not listed above: _____

SURGERIES & HOSPITALIZATIONS

Reason	Year	Hospital

CURRENT MEDICATIONS

Medication Name	Dosage	Frequency

ALLERGIES AND ADVERSE DRUG REACTIONS

Name of Drug	Reaction

FAMILY HEALTH HISTORY

List any medical problems your immediate family members have

HEALTH HABITS (INCLUDES PAST AND CURRENT USE)

Alcohol: ❑ No ❑ Yes	If yes, how many times per week?	How long?
Tobacco: ❑ No ❑ Yes	If yes, how many packs per day?	How long?

Drug use: ❑ Narcotics (prescription pain killers) ❑ Drug rehab ❑ Illegal drugs, which _____

ATTESTATION (PLEASE READ AND SIGN)

The information provided above is correct to the best of my knowledge. I have made no intentional error nor omitted information pertinent to my medical history or current medical status. I understand that omitting information could be dangerous. All information contained in this questionnaire is strictly confidential and will become part of my medical record.

X _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE