WARREN PODIATRY **HEALTH HISTORY FORM**

PATIENT NAME_____ **AGE**_____

Pharmacy: **Pharmacy Phone:**

Pharmacy address: **Pharmacy City:**

Please indicate with a (√) conditions Present and Past.

	YES	NO		YES	NO		YES	NO
Allergies or Hives			Anemia			Angina		
Arthritis			Artificial Heart Valve			Artificial Joints (hip, knee,etc.)		
Asthma			Bleeding Disorder			Blood Disorders		
Cancer			COPD			Diabetes		
Emphysema			Epilepsy			Gout		
Heart Disease or Attack			Heart Pacemaker			Heart Surgery		
Hepatitis (A,B, or C)			High Blood Pressure			High Cholesterol		
HIV/Aids			Kidney Trouble			Leg Ulcers		
Liver Disease			Muscular Problems			Phlebitis or Blood Clot		
Ears, nose, mouth			Psychiatric Treatment			Rheumatic Fever		
Skin Diseases			Stent in Heart			Stomach Ulcers		
Stroke			Tuberculosis			Urinary Problems		
Other Illnesses								

MEDICATION	DOSE	X PER DAY	MEDICATION	DOSE	X PER DAY

Past Surgeries, List and Year	Year		Year

Allergies and Reactions

Height_____ Weight_____ Shoe Size_____ Are you Pregnant? ☐ No ☐ Yes

Please select all that apply: Family history of ☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐ Cancer ☐ No history

Do you Smoke? ☐ No ☐ Yes ☐ Every day ☐ Occasional Pack/s per day _____

Did you ever Smoke? ☐ No ☐ Yes Date Quit: _____

Do you drink Alcohol? ☐ No ☐ Yes ☐ 1-2 per week ☐ 1-2 per day ☐ 2 + per day ☐ Monthly ☐ Occasional ☐ Never

Father Living/Deceased Mother Living/Deceased

Reason for visit: _____

Primary Care Physician: _____Date last seen:_____Phone: _____

I understand that the above information is necessary to provide me with Podiatric care in a safe and effective manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature (or responsible party): _____ Date: _____

This section to be completed by the doctor

Blood Pressure _____ Pulse _____

Doctor's Signature: _____ Date: _____ Reviewed with Patient: ☐ Yes ☐ No

DEMO____PPA_____HV_____DR. 1ST_____SOC/MED HISTORY_____PARENT_____PHARMACY_____