WARREN PODIATRY **HEALTH HISTORY FORM**

PATIENT NAME____ AGE______________

E-Mail **Pharmacy/Phone**

Cell Phone **Pharmacy Location**

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 Circle Type 1 Type 2		
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

Height__________ Weight__________ Shoe Size__________ Are you Pregnant? ☐ No ☐ Yes

Past Surgeries, List and Year ____

Allergies and Reactions:____

Please select all that apply: Family history of ☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐Cancer

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 or more per day

☐ Monthly ☐ a couple of times per year ☐ Never

Father or Mother's name:__________________________Date of Birth or approx. age:__________Living/Deceased

What is your chief foot concern? ____

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_____