



Medical History

Reason for Today's Visit

Patient's Name (Last, First, M.I.):		Date:
Please describe current problem:		
Which lower extremity: <input type="checkbox"/> Left <input type="checkbox"/> Right	How long has this problem troubled you:	
Have you undergone previous treatment for this problem: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:		
Is your problem a result of injury: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of injury:	Did injury occur while at work: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Medications (prescription and nonprescription medications)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Allergies

Please indicate: No known allergies Yes, please list below (medication, food, materials etc.)

Medical History (please check all that apply)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Arthritis/Bone-Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing/Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological Problems (Females)	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Head and Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack Date:	<input type="checkbox"/>	<input type="checkbox"/>
Blood or Blood Product Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Injury/Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dialysis (circle days) M T W T F S S	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Dropfoot	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>

