Name DOB Date

**Drug Allergies Current Medications Hospitalization Or Surgery**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Date | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Family History** - Please list any health problems and causes of death if applicable

|  |  |
| --- | --- |
| Father |  |
| Mother |  |
| Siblings |  |
| Grandparents - Mother |  |
| Grand Parents – Father |  |

# Medical History ( Yes / No )

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Headache |  | Lactose Intolerance |  | Depression |  |
| Shortness of Breath |  | Gallbladder Disease |  | Gout |  |
| Heart Palpitations |  | Prostate Disease |  | Scarlet Fever |  |
| Heart Murmur |  | Bowel Irregularity |  | Chronic Rashes |  |
| Chest Pain |  | Incontinence |  | Rheumatic Fever |  |
| Dizziness/Fainting |  | Sexual/Menstrual Dysfunction |  | Mumps |  |
| Peripheral Vascular Disease |  | Venereal Disease |  | Measles |  |
| Allergies/Hay Fever |  | Frequent Infections |  | Rubella |  |
| Asthma |  | Hepatitis |  | Polio |  |
| Bronchitis |  | Anemia |  | Diphtheria |  |
| Pneumonia |  | Arthritis |  | Tetanus |  |
| Ulcer |  | Osteoporosis |  | HIV/ADIS |  |
| GI Disorder |  | Nervousness |  | Other |  |

Do You use recreational Drugs ? Are you Sexually Active ? Yes

Yes No No

# Social History

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Smoke: | Packs Daily |  | Coffee: | Cups Daily |  | Sleep: | Difficulty falling asleep |  |
|  | How long? |  |  | Other Caffeine |  |  | Continuity disturbances |  |
|  | Interested to stop |  | Alcohol | Type |  |  | Snoring |  |
| Exercise: |  |  |  | Amount |  |  | Other |  |

**Women Only P**regnant? Yes / No Planning Pregnancy? Yes / No

Patient Signature:

Patient Name : Date:

|  |  |
| --- | --- |
|  | **Side of the Body** |
| **Back and Leg Pain (a)** | **Right Left Both None** |
| Pain in your lower back |  |
| Pain in your buttock |  |
| Pain or burning in your legs (440.22 ) |  |
| Numbness or tingling in your legs - (440.21) |  |
| Weakness in your legs |  |
| Loss of strength in your legs |  |
| Do you have an infection of the legs or feet that may be gangrenous ? ( 440.24) |  |
| **Foot Pain (b)** |  | **Right Left Both None** |
| Pain or burning in your feet (440.22) |  |
| Numbness or tingling in your feet (440.21) |  |
| Feels like pins and needles in your feet (440.21) |  |
| Increased sensitivity to touch on your feet(for example, it hurts when bed covers touch them) |  |
| Trouble feeling hot or cold in your feet |  |
| Trouble feeling your feet when you walk |  |
| Discomfort or pain at night in your feet (440.22) |  |
| Are your toes or feet pale, discolored or bluish ? (444.22) |  |
| Do you have skin wounds or ulcers on your feet that are slow to heal ? (707.10) |  |
| **Hand, Finger or Wrist Pain (c)** |  | **Right Left Both None** |
| Pain or burning in your fingers |  |
| Numbness or tingling in your fingers |  |
| Difficulty gripping things with your hands |  |
| Difficulty forming a fist with your hands |  |
| Discomfort in hands wakes you at night |  |
| **Diabetes Mellitus** |
| Do you have diabetes? | Type 1 | Type 2 No |