Carolina Podiatry Group, Inc.

INITIAL HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical with family physician _____

What is the reason for your visit today? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the recent past.

GENERAL

- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue/tired
- ☐ Sweats

MUSCLE/JOINT/BONE

- ☐ Stiffness ☐ Redness
- ☐ Pain ☐ Weakness
- ☐ Swelling ☐ Numbness
- ☐ Difficulty Walking
- ____ Arms ____ Hips
- ____ Back ____ Legs
- ____ Feet ____ Neck
- ____ Hands ____ Shoulders

URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Leaking urine
- ☐ Painful urination
- ☐ Urination during the night

ENDOCRINE

- ☐ Increased thirst
- ☐ Increased urination
- ☐ Increased hunger

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Bloating/Spasms
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Reflux
- ☐ Indigestion/Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Rectal bleeding/ Black stools
- ☐ Nausea

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Pain in calf muscles
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Swelling of legs/ankles

HEMATOLOGY

- ☐ B12 shots
- ☐ Anemia

RESPIRATORY

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Coughing up phlegm

EYE,EAR,NOSE,THROAT

- ☐ Bleeding Gums
- ☐ Vision problems
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay fever/allergies
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness
- ☐ Glasses ☐ Contacts
- ☐ Dentures ☐ Partial plate

SKIN

- ☐ Bruise easily
- ☐ Hives ☐ Itching
- ☐ Changes in moles
- ☐ Rash ☐ Scars
- ☐ Sore that won't heal
- ☐ Wound ☐ Ulcer
- ☐ Brittle hair ☐ Hair loss
- ☐ Nail changes

NEUROLOGY

- ☐ Headaches ☐ Migraines
- ☐ Dizziness ☐ Fainting
- ☐ Forgetfulness ☐ Numbness
- ☐ Weakness

PSYCHOLOGY

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Sleeping difficulties
- ☐ Panic attacks
- ☐ Suicidal thoughts

CONDITIONS Check (✓) conditions you currently have or have had in the past.

- ☐ AIDS/ HIV Positive
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis:type _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer: type _____
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Drug Dependency
- ☐ Diabetes: type _____
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease / Attack
- ☐ Hepatitis: type _____
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Pace Maker / Defibrillator
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Prostate Problems
- ☐ Stomach Ulcers
- ☐ Stroke/mini-stroke
- ☐ Suicide Attempt
- ☐ STDs
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Urinary Tract Infection
- ☐ Vascular Disease

Other: _____

_____

_____

_____

Carolina Podiatry Group, Inc
INITIAL HEALTH HISTORY (cont)

Please list any medical problems that you have not previously listed: _____

_____

List ALL surgeries that you have had: (not just foot/ankle related) _____

_____

List ALL medications you are currently taking: (include dosage & prescribing doctor) _____

_____

_____

Pharmacy Name _____ Phone No _____

Allergies: Food _____ Insects _____

Drug _____

_____

Do you smoke or use tobacco products? ____ If so, how often and for how long? _____
Do you drink alcoholic beverages? ____ If so, how often? _____

Does anyone in your family (mother/father/sister/brother) have any major medical problems? If so, list who and what. (mother - cancer) _____
_____

How long have you had your current foot/ankle problem? _____

What have you tried to treat this problem? _____

I attest that the above information is true to the best of my knowledge.

Signature _____ Date _____

FOR OFFICE USE ONLY

Weight: _____ Height: _____ Temp: _____ BP: _____/_____