## *NEW PATIENT HEALTH HISTORY FORM*

Patient Name_____ Date_____

DESCRIBE YOUR CURRENT FOOT PROBLEM

_____
_____
_____

PLEASE CIRCLE ANY ILLNESSES LISTED BELOW

MAJOR DISEASE:

Diabetes
Hypertension
Chest Pain
Heart Disease
Heart Attack
Arrhythmia
Murmur
Mitral Valve Prolepses
Stroke
Chest Pain

HEENT:

Headaches
Eye problems
Hearing Problem
Conditions

GASTROINTESTINAL:

Ulcers Stomach Problems
Bowel Disorders
Acid Reflux GI or Rectal
Bleeding Hiatal Hernia

RESPIRATOY:

Asthma
Bronchitis
Lung Disease
Shortness of Breath
Tuberculosis
Emphysema

ARTHRITIS:

Osteoarthritis
Rheumatoid
Gout

PSYCHOLOGIAL:

Anxiety
Depression
Psychiatric
Drugs
Alcohol
Dependence

NEUROLOGICAL:

BURNING NUMBNESS
TINGLING SHOOTING PAIN
LOSS OF FEELING

VASCULAR:

Anemia
Bleeding Disorders
Poor Circulation
Night Cramps
Leg Pain When Walking
Vein Problems
Spider Veins
Varicose Veins
Swelling Phlebitis
Leg Ulcerations
Blood Clots

MISCELLANEOUS:

Epilepsy
Thyroid Disease
Cancer History
Muscle Disease
Kidney Problems
Bladder Problems
Prostate Problems
Skin Conditions

**CURRENT MEDICATIONS**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

| Your Family Diseases: | Previous Surg/Hospital: | Other Medical History: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**ALLERGIES**

Penicillin Sulfa Aspirin Codeine Iodine/Shellfish Tape Latex
OTHER_____ NKDA

**SOCIAL HISTORY**

Tobacco Pk_____ Yrs_____ Alcohol Amount _____ Iv or Illicit Drugs Years Sober____

**Doctors Name:_____ Last Visit:_____ Surgeons:_____**

Shoe size_____ Type most worn_____ Job Description_____

**PLEASE REVIEW YOUR ABOVE INFORMATION AND BE SURE YOU FILLED IN ALL THAT APPLY.**

I hereby give my permission to Dr. John M. White, his associates, and assistants to examine, administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physician all benefits provided by my insurance company policy or policies for medical and surgical care. I understand that I am financially responsible for my balance due on my account.

**Signature of Responsible Party:_____ Date____/_____/_____**

**OFFICE USE ONLY**

**Vitals: BP: / P: R: T: HT: WT: Glucose: Appearance:**

**Derm: Neuro: Ortho: Vasc:**

**X-ray: Other Test/Labs: Notes:**

**Assessment: Plan:**

**PATIENT'S E-MAIL _____**
**WE ARE REQUIRED BY NEW MEDICARE/HEALTHCARE GUIDELINES TO HAVE A EMAIL ADDRESS SO YOU MAY ACCESS THE PATIENT PORTAL.**