

PATIENT MEDICAL HISTORY

FRED D YOUNG SWICK DPM
VINCENT C MARINO DPM
415 898 9818

Patient's Name \_\_\_\_\_

CIRCLE EACH ANSWER

- 1. Are you having pain or discomfort TODAY? YES NO
2. Have you had any surgeries before (not just foot-related)? YES NO
3. Have you been a hospital patient during the past 2 years? YES NO
4. Have you been under the care of any doctor during the past 2 years? YES NO
5. Have you taken any medications or drugs during the past 2 years? YES NO
6. Are you now taking any medications or pills? YES NO
7. Are you aware of being allergic to/have you ever reacted adversely to any medications or substances? YES NO
8. When you take a walk or walk up stairs, do you ever have to stop because of pain in your chest or calves or because you are short of breath? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you have difficulty when taking anti-inflammatory medicine (Advil, Aleve)? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Has your doctor ever said you have cancer or a tumor? YES NO
13. CIRCLE each of the following which you currently have or have had:

Table with 4 columns listing medical conditions: Heart Failure, Arthritis, Chronic Cough, HIV, Heart Disease/Attack, Rheumatism, Tuberculosis, Hemophilia, Angina Pectoris, Cortisone Medicine use, Asthma, Anemia, Congenital Heart Disease, Drug Addiction, Hay Fever, Sickle Cell Disease, Heart Murmur, Stroke, Allergies/Hives, Bruising Easily, High Blood Pressure, Artificial Joints (hip, knee), Radiation Therapy, Liver Disease, Arteriosclerosis, Kidney Trouble, Chemotherapy, Yellow Jaundice, Artificial Heart Valve, Ulcers, Hepatitis A (Infectious), Epilepsy/Seizures, Mitral Valve Prolapses, Diabetes, Hepatitis B (Serum), Fainting/Dizzy Spells, Heart Pacemaker, Thyroid Problems, Hepatitis C, Nervousness, Rheumatic Fever, Glaucoma, Venereal Disease, Psychiatric Treatment, Deep Vein Thrombosis, Emphysema, AIDS

- 14. PRINT other disease/condition/problem you have \_\_\_\_\_
15. Do you drink alcohol? YES NO
16. Do you smoke cigarettes? YES NO
17. Height \_\_\_\_\_ Weight \_\_\_\_\_
----FOR WOMEN ONLY ----
18. Are you taking birth control pills? YES NO
19. Are you pregnant? YES NO
If YES, what month? \_\_\_\_\_
20. Are you nursing? YES NO

I, the undersigned, understand the above information is necessary to provide me with the best medical care in a safe, efficient manner. I have answered all questions truthfully and to the best of my knowledge:

Patient's Signature (or that of a Parent of Guardian for a minor)

Date