STONESTOWN PODIATRY GROUP

Patient Medical History

1. Name of your Physician _____ Phone _____

   Address _____

2. Are you having pain or discomfort at this time? ..... YES NO
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs, or pills? ..... YES NO

   If yes, please list _____

6. Are you aware of being allergic to or having ever reacted adversely to any medication or substance? YES NO

   If yes, please list _____

7. Please mark an "X" for any medical condition you have had or have at present:

Heart Failure _____	Hepatitis B (serum) _____	Kidney Trouble _____
Heart Disease or Attack _____	Artificial Joints(hip,knee,etc.) _____	Venereal Disease _____
Angina Pectoris _____	Ulcers _____	A.I.D.S. _____
Congenital Heart Disease _____	Diabetes _____	H.I.V. Positive _____
Heart Murmur _____	Cold Sores/Fever Blisters _____	Thyroid Problems _____
High Blood Pressure _____	Glaucoma _____	Blood Transfusions _____
Arteriosclerosis _____	Sinus Troubles _____	Hemophilia _____
Mitral Valve Prolapse _____	Emphysema _____	Anemia _____
Artificial Heart Valve _____	Chronic Cough _____	Sickle Cell Disease _____
Heart Pacemaker _____	Tuberculosis _____	Bruise Easily _____
Heart Surgery _____	Asthma _____	Liver Disease _____
Rheumatic Fever _____	Hay Fever _____	Yellow Jaundice _____
Arthritis _____	Allergies or Hives _____	Epilepsy or Seizures _____
Rheumatism _____	Fainting or Dizzy Spells _____	Cosmetic Surgery _____
Cortisone Medicine _____	Radiation Therapy _____	Nervousness _____
Stroke _____	Chemotherapy _____	Psychiatric Treatment _____
Hepatitis A (infectious) _____	Developmentally Disabled _____	

8. Do you smoke? _____ How much per day? _____ Do you drink alcohol? _____ How much per week? _____
9. When you walk stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... _____
10. Do your ankles swell during the day? ..... _____
11. Do you use more than two pillows to sleep? ..... _____
12. Have you lost or gained more than 10 pounds in the past year? ..... _____
13. Do you every wake up from sleep and feel short of breath? ..... _____
14. Are you on a special diet? ..... _____
15. Has you medical doctor ever said you have a cancer or tumor? ..... _____
16. Do you have (of have you had) and disease, condition, or problem not listed? ..... _____

    If yes, please list _____

FOR WOMEN ONLY:

Are you pregnant? ____ Yes, what month? _____ ____ No

Are you nursing? ____ Yes ____ No Are you taking birth control pills? ____Yes ____ No

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

_____ _____

Patient Signature (or that of Parent or Guardian for minor) Date