Tri-City Podiatry Group

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Date:

PATIENT MEDICAL HISTORY

Patient Name:_____ **Date Of Birth:** _____

Reason For Visit:_____

Medications - **Please List OR Attach a copy of ALL current medications including dosage and frequency:**

_____ _____ _____

_____ _____ _____

Allergies: **Are you Allergic to OR had any reaction from: (***PLEASE CIRCLE ALL THAT APPLY***)**

Aspirin Adhesive Tape Codeine Iodine Morphine Novocain Penicillin Sulfa Drugs Tetanus

Please list any other Allergies:

_____ _____ _____

_____ _____ _____

Medical History :(*PLEASE CIRCLE ALL THAT APPLY***)**

Anemia Arthritis Asthma Cancer COPD Chickenpox Diabetes Emphysema

Gout Heart Disease Heart Attack/Stroke High Blood Pressure Kidney Disease

Liver Disease Measles Mumps Phlebitis (Blood Clots) Pneumonia

Surgical History: (*PLEASE LIST PROCEDURE AND DATES***)**

_____ _____ _____

_____ _____ _____

Social History: (*PLEASE CIRCLE ALL THAT APPLY***)**

Tobacco Use:	Never	Previously but quit	Yes, Packs/Day _____
Alcohol Use:	Never	Previously but quit	Yes, Amount _____
Other Drug Use:	Never	Previously but quit	Yes, What? _____

Could you be Pregnant or are you Pregnant? ☐Yes ☐No