Patient's Name________________________

Review of Systems: (please indicate yes or no)

Constitutional
- Fever Y N
- Weight change Y N

Eyes
- Visual change Y N

Ears, Nose, Mouth
- Hearing change Y N
- Sinus problems Y N
- Dental problems Y N

Cardiovascular
- Chest pain Y N
- Hypertension Y N
- Shortness of breath Y N

Respiratory
- Tuberculosis Y N
- Pneumonia Y N
- Asthma Y N

Endocrine
- Diabetes Y N
  - If yes – Insulin Dependent Y N / Last Blood Sugar_____________ Last Hemoglobin AIC ______________
- Thyroid problem Y N

Gastrointestinal
- nausea/vomiting Y N
- blood in stool Y N

Genitourinary
- urinary infections Y N
- incontinence Y N

Skin
- infections Y N
- lesions/ulcers' Y N

Neurologic
- seizures Y N
- paralysis Y N

Psychiatric
- Depression Y N

Hematologic
- blood clots Y N
- bleeding Y N

Past Medical History: (please list those medical conditions/illness) **This does not include surgeries. (Lifetime)**

1.______________________________ 2.______________________________
3.______________________________ 4.______________________________
5.______________________________ 6.______________________________

Past Surgical History: (please list prior surgeries, especially those related to your current problem). **(Lifetime)**

1.______________________________ 2.______________________________
3.______________________________ 4.______________________________

Allergies: (please list)____

____

Medication: (please list name, dose, and frequency)

1.______________________________ 2.______________________________
3.______________________________ 4.______________________________
5.______________________________ 6.______________________________
7.______________________________ 8.______________________________

Family Medical History: (list medical illnesses affecting your immediate family)

1.______________________________ 2.______________________________
3.______________________________ 4.______________________________

Social History: (please check all apply)

tobacco use (packs per day): ______________________
alcohol use (drinks per week): _____________________
recreational drug use? _____________________________

This document was reviewed by ____________________________________, Podiatric Assistant Date ______________________

This document was reviewed by ____D.P.M. Date ______________________