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
- Thyroid problem Y N
- Diabetes Y N

If yes – Insulin Dependent Y N / Last Blood Sugar_____ Last Hemoglobin AIC _____

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. i.e. diabetes, heart disease, cancer, etc.)

Father-_____ Living or Deceased (Cirlcle one) Siblings-_____ Living or Deceased
Mother- _____ Living or Deceased (Cirlce One) Other- _____ Living or Deceased

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 _____