

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**MEDICAL HISTORY**

MAIN REASON FOR TODAY'S VISIT? (DESCRIBE LOCATION AND NATURE OF PROBLEM)

HOW LONG HAS THIS BEEN BOTHERING YOU?

WHAT TREATMENTS HAVE YOU TRIED?

**ALLERGIES:** Type of Reaction? Location?  None  Penicillin  Sulfa  Codeine  Aspirin  Tape  Latex  Iodine

**Other Medicines, Foods:** Type of Reaction? Location? 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**MEDICATIONS:** What medications are you currently taking? Dosage? (Include OTC, vitamins, herbs)

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

**PAST MEDICAL HISTORY**

Please indicate whether you have had any of the following medical conditions:

	Yes	No		Yes	No
Heart Disease/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angia	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Weakness In Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Numbness In Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Shortness Of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease/ Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis/Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
GERD/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Changes/Loss Of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatologic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (What Type?)	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
DVT(Blood Clot)/PE	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Raynaud's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vasc. Disease	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions:	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Fractures (When/Where?)					
Joint Replacement (Which?)					
Other Condition(s)					

**FAMILY HISTORY**

Please check if any of your family members have/had any of the following:

	Yes	No		Yes	No
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bunion	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Bunionette	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	High Arched Feet	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Pigeon-toed Feet	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hammertoes	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Chronic ingrown nails	<input type="checkbox"/>	<input type="checkbox"/>
Other(Please specify):					

**SOCIAL HISTORY**

	Yes	No	Details
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	# Years? ___ Packs/day: ___
Did you ever smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Quit date: ___ # Years? ___ Packs/day ___
Caffeine? (tea/coffee)	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day ___
Current Alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	#Drinks per week? ___ ___ Beer ___ Wine ___ Liquor
Past Alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	#Drinks per week? ___ ___ Beer ___ Wine ___ Liquor
Current or past illicit drug use/ abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Where Born			
Occupation			
Recent Travel Abroad?			
Other Pertinent Social History Details			

**PAST SURGICAL & HOSPITALIZATION HISTORY**

Procedure	Year	Hospitalizations (reason)	Year
1.			
2.			
3.			

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BP:** \_\_\_\_\_ **PULSE:** \_\_\_\_\_ **SHOE SIZE:** \_\_\_\_\_

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT(OR GUARDIAN): \_\_\_\_\_ DATE: \_\_\_\_\_



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