

**Medical Information / Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Did someone refer you to my office?** \_\_\_\_\_

**Who is your Primary Medical Doctor?** \_\_\_\_\_

**Chief Complaint (Briefly Describe): 1)** \_\_\_\_\_

**2)** \_\_\_\_\_

**How long have you been suffering?** Days Weeks Months Years

**How did it start (circle):** Gradual Sudden Result of Injury With Exercise With a New Job Other: \_\_\_\_\_

**Course:** getting better getting worse no change **Aggravating Factors:** \_\_\_\_\_

**Have you treated the Condition (Circle):** Rest Ice Ibuprofen Aleve Tylenol Shoe Modification Other: \_\_\_\_\_

**Past Medical History: (Please circle all that apply) \_\_\_\_\_ (check) I do not have any medical conditions**

High Blood Pressure	Asthma	Psoriasis	Blood Disorder
Heart Disease	Emphysema	Eczema	Melanoma
Coronary Art. Dis.	Kidney Disease	History of Gout	Skin Cancer
Heart Attack	Dialysis	Psoriatic Arthritis	Leg Ulcer
Congestive Hrt Failure	Thyroid Disorder	Osteoarthritis	Transfusion
Carotid Artery Disease	Graves Disease	Rheumatoid Arthritis	Chemotherapy
High Cholesterol	Acid Reflux	Breast Cancer	Radiation Therapy
Stroke	GERD	Ovarian Cancer	History of Hepatitis
Poor Circulation	Hiatal Hernia	Uterine Cancer	HIV
Leg Cramps	Stomach Ulcer	Lung Cancer	Other: _____
Diabetes	Liver Disease	Prostate Cancer	

**What kind of surgery have you had? (Circle all that apply) \_\_\_\_\_ (check) I do not have any medical conditions**

Ankle Surgery	Fibroid Surgery	Mastectomy Single/Double
Appendectomy	Foot Surgery	Ovarian Surgery
Adenoid	Gallbladder Surgery	Tonsillectomy
Abdominal Surgery _____	Heart Surgery	TURP
Back Surgery	Hip Replacement	Gastric bypass
Brain Surgery	Kidney Surgery	Intestinal Surgery
Hysterectomy	Knee Replacement	Cosmetic Surgery

**Please list all medication allergies:**  None

**Please list all of your medications:** \_\_\_\_\_

**How Tall Are You?** Ft in **Weight** lbs

**Do you Smoke?** No Quit Yes Cigarettes a day Pack/Day How many years?

**Do you drink alcohol?** Beer / Wine / Hard Liquor How Much? /Day /Week

**Family History (Circle all that apply. Mother / Father / Sibling):**

Heart Disease M / F / S	Hammertoes M / F / S	Gout M / F / S
Stroke M / F / S	Diabetes M / F / S	Kidney Disease M / F / S
Circulation Problems M / F / S	Neurological Disorder M / F / S	Bleeding Problem M / F / S
Flat Feet M / F / S	Rheumatoid Arthritis M / F / S	
Bunions M / F / S	Osteoarthritis M / F / S	

**What kind of exercise do you do and how often?** \_\_\_\_\_

**What type of job do you do? (Circle)** Sit Stand Stands & Walks Retired Revised 01-2012