MEDICAL HISTORY

JOEL BOWEN DPM

PATIENT NAME: (LAST, FIRS, MI):_____**MRN**_____

- **ALLERGIES TO MEDICATION:** _____ **REACTION:** _____
- **ALLERGIES TO MEDICATION:** _____ **REACTION:** _____
- **ALLERGIES TO MEDICATION:** _____ **REACTION:** _____

PRESCRIPTION MEDICATIONS:

MEDICATION: _____ MEDICATION: _____ _____

MEDICATION: _____ MEDICATION: _____

MEDICATION: _____ MEDICATION: _____

MEDICATION: _____ MEDICATION: _____

MEDICATION: _____ MEDICATION: _____

PREVIOUS SURGERIES :(ADDITONAL ON BACK)

- TYPE: _____ YEAR:_____
- TYPE: _____ YEAR:_____
- TYPE: _____ YEAR:_____

SELECT ONE:

- DO YOU HAVE LOW BACK PAIN? ☐ YES ☐NO
- HISTORY OF DRUG ABUSE? ☐ YES ☐NO
- DO YOUU DRINK ALCOHOL? ☐ YES ☐NO AMOUNT:_____
- DO YOU SMOKE? ☐ YES ☐NO AMOUNT: _____ HAVE YOU QUIT? ☐Y ☐ N
- ARE YOU CURRENTLY PREGNANT? ☐ YES ☐NO # OF MONTHS _____

▪ **Patient Pharmacy:** _____

Location**:** _____

▪ **Living Will/Power of Attorney** ☐ Y ☐ N

MEDICAL PROBLEMS:

Please Check If you Have/Have Had the Following:

☐ Arthritis select: ☐Rheumatoid ☐ Osteo

☐ Asthma ☐ Gout ☐ Neuropathy

☐ Anemia ☐ High Blood Pressure ☐ Stomach Problems: Type:_____

☐Aids/HIV ☐ High Cholesterol ☐ Stroke

☐ Blood Clots ☐ Hepatitis select: ☐ A ☐B ☐ C ☐

☐ Bleeding Disorder ☐ Heart Problems: Type: _____

☐ COPD ☐Kidney disease ☐ Thyroid Problems

☐ Diabetes/ Results of Last Blood Sugar/Hba1c:_____

☐ Fibromyalgia ☐ Liver trouble ☐ varicose veins

Other: _____

FAMILY HISTORY (SELECT ALL THAT APPLY)

☐ HYPERTENSION	☐ MOTHER	☐ FATHER	☐ GRANDPARENT	☐ SIBLING
☐ HEART DISEASE	☐ MOTHER	☐ FATHER	☐ GRANDPARENT	☐ SIBLING
☐ DIABETES	☐ MOTHER	☐ FATHER	☐ GRANDPARENT	☐ SIBLING
☐ FOOT PROBLEMS	☐ MOTHER	☐ FATHER	☐ GRANDPARENT	☐ SIBLING

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

▪ I understand that honest and complete answers to each question stated above are important to the provision of my medical care, and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the forms, I should ask the doctor or member of the medical staff for assistance. This information is true and accurate to my knowledge.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____