PATIENT MEDICAL HISTORY FORM *Todd Rotwein, DPM / Nassau Podiatric Surgical Offices, PC*

Name	Date of Birth	Gender M/F	Height	Weight	Patient ID#
			ft in	lbs	*Office use only*

Primary Care Physician (PCP): _____ Today's Date:_____

PCP Street address: _____ Are you: ___right-handed ___left-handed?

PCP Town, Zip: _____ PCP Phone #: _____

Medications: Prescription and non-prescription, vitamins, home remedies, birth control pills, herbs, herbal teas:

Medication	Dose	Times/day

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Allergies or Reactions to Medicines/Foods/Other Agents:

Allergic to:	Reaction or Side Effect

Surgical History: Please list all prior operations (with dates):

_____

_____

Review of Symptoms: Please check (√) any current symptoms you have.

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Cardiovascular
___ Chest pains/discomfort
___ Palpitations
___ Short of breath with exertion
___ Swelling in feet or ankles

Skin
___ Difficulty healing wounds
___ Excessive scarring
___ Rash
___ New or change in mole

Neurological
____Headaches
____Fainting or dizziness
____Numbness in foot or leg

Eyes
____Change in vision

Psychiatric
____Anxiety/stress
____Sleep problem

Respiratory
____Cough/wheeze
____Coughing up blood

Musculoskeletal
____ Foot or ankle pain
____ Leg pain while sleeping
____ Muscle/joint pain
____ Pain in lower leg while walking
____ Recent back pain

Endo
____ Cold/heat intolerance
____ Increase thirst/appetite

Other
____ _____
____ _____

Personal Medical History: Please check (√) if you have had any of these medical problems:

___ Diabetes
___ Circulation problems
___ Difficulty healing wounds
___ Excessive scarring
___ Bleeding abnormalities
___ Anemia
___ Hepatitis
___ Phlebitis
___ Heart problems
___ Asthma/Lung problems
____Arthritis
____Blackouts
____Convulsions
____Emphysema
____Gout
____Liver problems
____High blood pressure
____Kidney disease
____Fainting episodes
____AIDS / STDs / Venereal Disease
___ Lower back problems
___ Sciatica
___ Varicose veins
___ Thyroid problem
___ High cholesterol
___ Rheumatoid arthritis
___ Stroke
___ Ulcers
___ Cancer (type): _____

Signature _____ Date _____

Doctor's Signature _____ Date _____