Comprehensive History Form

Name: ______________________________ **Family Physician:** ________________________

Family Physician Address: ____

Family Physician Phone: (   )____________________ Date Last Seen: ______________________

Age: ______ Height: _________ Weight: _________ Shoe Size: ____________

Have you been treated by a Specialist: ❑ Yes ❑ NO If yes, for what condition: __________
____

Review of Systems: (Check any of the following that you have, or have had in the past)

- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Fatigue
- ❑ Blurry Vision
- ❑ Double Vision
- ❑ Ringing in ears
- ❑ Hearing Loss
- ❑ Sinus Congestion
- ❑ Bloody Nose
- ❑ Loss of Taste
- ❑ Dry Mouth
- ❑ Sore Throat
- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Shortness of Breath
- ❑ Trouble Breathing
- ❑ Cough
- ❑ Upset Stomach
- ❑ Diarrhea
- ❑ Bloody Stools
- ❑ Frequent Urination
- ❑ Burning with Urination
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Muscle Weakness
- ❑ Rashes
- ❑ Sores
- ❑ Numbness
- ❑ Poor Balance
- ❑ Anxiety
- ❑ Depression
- ❑ Hair Loss
- ❑ Excessive Thirst
- ❑ Easy Bruising
- ❑ Food Allergies
- ❑ Seasonal Allergies

If none of the above please indicate with a check mark in the box: ❑ (None)

Past Medical History:

Ulcers	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No

Other ___________________________

Medications: (Name, Dose and How Often Taken)
(If you have a current list we will copy it)

1 ____
____
2 ____
____
3 ____
____
4 ____
____
5 ____
____

Previous Surgery (s): You may use back of form if necessary

1 ____
2 ____
3 ____
4 ____

Allergies: ____

____

____

Family History:

Does Anyone in Your Family Have a History of any of the following:

		Family Member
High Blood Pressure	❑ Yes ❑ No	____________
Diabetes	❑ Yes ❑ No	____________
Heart Disease	❑ Yes ❑ No	____________
Stroke	❑ Yes ❑ No	____________
Cancer	❑ Yes ❑ No	____________
Thyroid Disease	❑ Yes ❑ No	____________

Is your father: Living or Deceased Cause of Death ____________

Is your mother: Living or Deceased Cause of Death ____________

Social History:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you live alone? ❑ Yes ❑ No

Occupation: ____________________________

Do you smoke? ❑ Yes ❑ No If yes, how much per day ________ How many years? ____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? ________________

Do you exercise? ❑ Never ❑ Rarely ❑ Regularly

Patient Signature: ____________________ Date: ______________

Reviewed By: ________DPM Date __________ , 200_

(Please Initial) ________DPM Date __________ , 200_

________DPM Date __________ , 200_

________DPM Date __________ , 200_

________DPM Date __________ , 200_

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