

MEDICAL HISTORY FORM

CALLAHAN PODIATRY, INC.

DATE: _____

PROVIDER: Daniel E. Callahan, DPM

PATIENT NAME: _____
LAST FIRST MIDDLE

DOB: _____

WHAT IS YOUR CURRENT FOOT PROBLEM? _____

WHEN AND HOW DID THIS PROBLEM FIRST BEGIN? _____

WHAT HAVE YOU DONE, OR WHAT HAS YOUR FAMILY DOCTOR RECOMMENDED FOR THIS PROBLEM? _____

PAST MEDICAL HISTORY

FAMILY DOCTOR NAME: _____

PHONE: _____

ADDRESS: _____

DATE LAST SEEN: _____

DATE OF LAST COMPLETE PHYSICAL EXAM: _____

LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING (INCLUDING ASPIRIN, VITAMINS AND OVER THE COUNTER): _____

LIST **ALLERGIES** OR UNUSUAL REACTIONS TO MEDICATIONS (IF NONE PLEASE STATE "NONE"): _____

CIRCLE ANY OF THESE CONDITIONS YOU NOW HAVE OR HAVE BEEN TREATED FOR:

- | | | | |
|--------------------|---------------|-----------------------|---------------|
| Anemia | Diabetes | High Blood Pressure | Tuberculosis |
| Asthma | Epilepsy | Kidney disease | Ulcers |
| AIDS/ARC | Glaucoma | Liver trouble | Scarlet Fever |
| Anesthesia trouble | Gout | Mitral valve Prolapse | Phlebitis |
| Arthritis | Heart Disease | Nervous condition | Blood clots |
| Bleeding trouble | Heart Murmur | Depression | Lung disease |
| Cancer | Hepatitis | Rheumatic Fever | Nerve damage |
| Stroke | Other _____ | | |

DESCRIBE ANY INJURIES OR FRACTURES OF YOUR LEGS, ANKLES, OR FEET: _____

LIST ANY SURGICAL PROCEDURES OR HOSPITALIZATIONS: _____

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE EXPLAIN BELOW:

- | | | |
|---|-----|----|
| Do you have any vascular grafts? | Yes | No |
| Have you had any joint replacement surgery? | Yes | No |
| Do you have replacement heart valves? | Yes | No |
| Are you now under active chemotherapy? | Yes | No |

NUMBER OF CHILD-BIRTHS: _____

ARE YOU CURRENTLY PREGNANT? Yes No

ANY COMPLICATIONS WITH PREGNANCY OR CHILDBIRTH? Yes No

ARE YOU SLOW TO HEAL AFTER CUTS? Yes No
 ANY ABNORMAL BRUISING, BLEEDING, OR SCARRING? Yes No

DID YOU PREVIOUSLY OR DO YOU NOW WEAR:

Shoe inserts? Yes No Still using them? Yes No Did they help? Yes No
 Orthotics? Yes No Still using them? Yes No Did they help? Yes No

IF YOU HAVE ORTHOTICS, PLEASE MARK WHERE YOU OBTAINED THEM:

___ Another Podiatrist ___ An Orthopedist ___ A Physical Therapist
 ___ A Chiropractor ___ Other: _____

FAMILY HISTORY

	Age	Cancer	Heart Disease	Kidney Disease	Diabetes	High Blood Pressure	Lung Disease	Other
Mother								
Father								
Brothers								
Sisters								

SOCIAL HISTORY

DO YOU USE TOBACCO NOW? Yes No ___ pack(s) per day

OR
 DID YOU USE TOBACCO PREVIOUSLY? Yes No ___ pack(s) per day Date you quit? _____

DO YOU USE ALCOHOL NOW? Yes No ___ drink(s) per DAY WK MO

OR
 DID YOU USE ALCOHOL PREVIOUSLY? Yes No ___ drink(s) per DAY WK MO Date you quit? _____

DO YOU USE OTHER DRUGS OR HAVE A HISTORY OF RECREATIONAL DRUG USE? Yes No

DO YOU DRINK CAFFEINE CONTAINING BEVERAGES? Yes No ___ per day

DO YOU EXERCISE OR PLAY SPORTS ON A REGULAR BASIS? _____

DO YOU CURRENTLY WORK OUTSIDE THE HOME? Yes No Retired

If so is your job primarily sitting OR walking/standing ?

Does it involve heavy lifting AND/OR climbing ?

Are you required to wear special shoes for work? (for example steel toes, non-skid soles, etc) Yes No

Describe: _____

Please list any other medical problems, concerns, conditions, or any other information you feel is important for the doctor to know:

I realize that it is important to provide the above information to my podiatrist, and that any or all of the above can affect my foot problems and may be used by the doctor in helping to determine my best treatment options.

I certify that the above is accurate and up to date.

Signed: _____

Date: _____