Mercer-Ocean Podiatry, PC

Dr. Frank Killian, DPM, FACFAS *Dr. Sameep Chandrani, DPM, AACFAS*

PATIENT MEDICAL HISTORY

PATIENT INFORMATION

Patient Name (Last, First, MI): Date:

Statistics: Height: Weight: Shoe Size:

Chief Complaint (Please describe current problem):

MEDICATIONS (PRESCRIPTION & NONPRESCRIPTION)

Medication Name	Dosage	Medication Name	Dosage

ALLERGIES

Please List:

MEDICAL HISTORY (Please CHECK all that apply)

☐ Arthritis/Bone-Joint Problems	☐ Lyme Disease
☐ Anemia	☐ Neuromuscular Disease
☐ Asthma/Lung Problems	☐ Numbness/Weakness
☐ Back Problems	☐ Pacemaker
☐ Bleeding Problems	☐ Polio
☐ Blood Clots	☐ Positive Culture for MRSA/VRE
☐ Cancer	☐ Positive Test for HIV
☐ Chemotherapy	☐ Previous or Current Diabetic Foot Wounds
☐ Chest Pain/Heart Problems	☐ Prostate Problems (Males)
☐ Circulatory Problems	☐ Recent Weight Gain/Loss
☐ Diabetes Type 1	☐ Scoliosis
☐ Diabetes Type 2	☐ Seizures/Epilepsy
☐ Dropfoot	☐ Sickle Cell Disease or Trait
☐ Eye Problems	☐ Skin Problems/Cancer
☐ Gout	☐ Sleep Apnea
☐ Gynecological Problems (Females)	☐ Stroke Date:
☐ Head and Neck Problems	☐ Stomach/Intestinal Problems/Ulcers
☐ Heart Attack Date:	☐ Tetanus Immunization Date:
☐ Hepatitis/Liver Disease	☐ Thyroid Problems
☐ High Blood Pressure	☐ Tuberculosis
☐ High Cholesterol	☐ Urinary Tract Problems
☐ Injury/Trauma Kidney Problems	
☐ Kidney Dialysis	☐ No Past Medical History
☐ Lower Extremity Wounds	

Please list any other medical conditions not mentioned above:

Details regarding ANY significant health events in the past 6 months:

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FAMILY HISTORY
Mother: Living _____ Deceased _____ Father: Living _____ Deceased _____ Siblings: Indicate # of siblings _____
Does anyone in your IMMEDIATE family have any of the previously mentioned medical problems? If yes, please describe:

SURGICAL HISTORY
Please list the surgery and date performed:
Do you have any internal metal or other implants (pins, grafts, screws, plates, clips, joints)? If yes, please describe:

SOCIAL HISTORY				
Do you smoke? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Do you drink? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Use recreational drugs? (Circle One)	YES	NO	If yes, how much?	If you quit, when?
Are you pregnant? (Circle One)	YES	NO	If no, are you trying to become pregnant? (Circle One)	YES NO
Do you participate in physical fitness activities? (Circle One)	YES	NO	If yes, how often?	

OFFICE INFORMATION

ADVERTISING
How did you learn about our practice? (Circle One)
Friend Patient Relative Doctors Office Internet Insurance Carrier Newspaper/Magazine Other:

WEBSITE
Did you find our website helpful? (Circle One) YES NO Did Not Use

Our office maintains compliance with the infection control standards mandated by the CDC and OSHA

PLEASE SIGN
To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be hazardous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff of Mercer – Ocean Podiatry, P.C. to perform the necessary services I may need.
Signature of Patient or Parent of Minor: _____ Date: ___ / ___ / _____