



Concord Podiatry Medical History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Please circle: Male Female **Referred by:** _____

Primary Care Physician: _____ **ARNP:** _____

How did you hear about us? _____

Chief Foot Complaint: _____

Allergies to Medications: _____

List of All Medications, Including over-the-counter medications, vitamins/minerals and blood thinners:

Do you smoke: Yes No

Do you drink Alcohol: Yes No

Are you Pregnant: Yes No

Any Family History of: (Please Circle)

High Blood Pressure Diabetes Cancer Stroke Heart Problem Arthritis None

Surgery History: (Please Circle)

Heart surgery Joint replacement Vascular Surgery Back Surgery None

Have you had foot surgery due to Diabetes: Yes No

Other Surgeries:



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Personal Medical History: (Please Circle)

- | | | |
|---------------------|---------------------|-------------------------|
| Anemia | High Blood Pressure | Anaphylaxis |
| Artificial Joint | Stroke | Hepatitis/Liver Disease |
| Cancer | Bleeding Disorder | Kidney Disease |
| Emphysema | Tuberculosis | Lung Disease |
| Arthritis | Gout | Osteoporosis |
| Asthma | Thyroid Disease | Low Back Pain |
| Chest Pain | Psychiatric Care | Poor Circulation |
| Epilepsy or Seizure | Stomach Ulcer | Blood Clots/DVT |
| Glaucoma | Neuropathy | Foot Ulcer |
| Heart Conditions | Atrial Fibrillation | MRSA Infection |

Diabetes: Yes No Type 1 Type 2

Doctor: _____

Date Last Seen: _____ Last A1C: _____ This Mornings Blood Sugar _____

Do you take: (Please Circle) Insulin Orals Both Neither

Other Conditions Not Mentioned

Here: _____

Height: _____ Weight: _____ ShoeSize: _____ Pharmacy/Location: _____

Signature: _____ Date: _____

Thank you for taking the time to fill out this form. This will help us give you the best podiatric care.

Dr. Biss, Concord Podiatry 163 Manchester St, # 3. P: 603-224-1800, F: 603-224-3900