Southern Tier Podiatry

~ Dr. Marilyn Boyuka ~

Patient Name: ______________________________ **Date of Birth:** ___/___/______

Reason for today's visit: ____

Patient's Past Medical History:

Height: _______ Weight: ______________

List all previous Surgeries and/or Hospitalizations with date:

____

____

____

Do you have a history of, or currently experience, any of the following medical conditions? (Please check or circle all that apply)

- o Asthma / Bronchitis / Pneumonia
- o Heart disease/Congestive Heart Failure
- o Heart Valve Replacement (Mitral/Aortic)
- o Heart Surgery
- o Irregular heart beat/heart murmur/A-fib
- o High Blood Pressure
- o GI/stomach problems/GERD/Acid Reflux
- o Bleeding disorders
- o Blood Clots(DVT/PE)
- o Seizures/Epilepsy
- o Shortness of breath/Emphysema/COPD
- o Tuberculosis
- o Depression / Bipolar / Anxiety Disorder
- o Osteoarthritis/Rheumatoid arthritis/ Psoriatic Arthritis/ Lyme Disease
- o Lupus /Other Autoimmune Disease __________________
- o Diabetes (insulin/non-insulin/diet controlled)
- o Thyroid disease
- o Kidney Disease / Dialysis
- o Liver Disease / Hepatitis (Type__________)
- o Artificial Joint Replacement _______________
- o Swollen legs / Venous Insufficiency/ Vein Problems/Phlebitis/Varicose Veins
- o Peripheral Arterial Disease(PAD)/(PVD)
- o Carotid Artery Disease
- o Back Pain/ Pinched Nerve/Bulging Disc
- o Numbness/Tingling to feet/toes
- o Cancer ________________________________
- o Other medical condition(s)________________ ____

Patient's Family Medical History: (Please check or circle all that apply)

- o Psoriatic arthritis / Rheumatoid arthritis
- o Heart disease / Circulation Problems
- o Cancer (Melanoma/Other ______________)
- o Diabetes
- o Lupus/ other Autoimmune disease ________________________________
- o Other Relevant Family Medical History: ____

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Patient's Social History:

I am: (circle one) Married / Separated/ Divorced / Single /Widowed

Do you Smoke? How many packs per day? _______ How many years? ___________
Do you Consume Alcohol? #drinks _______ / per week
Do you have any History of Illicit Drug Use/ Addiction History? (Circle one)
Yes (drug(s): ____)/ no
Do you have any History of Pain Medication Misuse/Addiction History? (Circle one)
Yes (drug(s): ____)/ no

Allergies:

Drug:__________________________________ **Reaction:** ____

Severity:(circle one) very mild / mild / moderate / severe **Onset:** (circle one)unknown/ adult / childhood

Drug:__________________________________ **Reaction:** ____

Severity:(circle one) very mild / mild / moderate / severe **Onset:** (circle one)unknown/ adult / childhood

Current Medication List :

Medication	Dosage	Frequency Taken