FACULTY PHYSICIANS KNOXVILLE

Podiatry
Medical History Form – Please Fill Out Completely

Last Name _____ First Name _____

Birthdate _____ Age _____ Height _____ Weight_____

Primary Care Provider_____ How did you hear about us? _____

Do you have, or are you being treated for any of the following? (Check all that apply)

☐ High Blood Pressure	☐ Pacemaker	☐ Blood clots
☐ Kidney Disease	☐ Bleeding Problems	☐ Asthma
☐ Emphysema	☐ Stomach/colon disease	☐ Cancer
☐ Diabetes	☐ Ulcers	☐ Hepatitis
☐ Seizures	☐ Stroke	☐ HIV/AIDS
☐ Heart Disease	☐ Neuropathy	☐ Other _____

If you have diabetes, who manages it? (Provider and practice name) _____

List all previous surgeries. Use back if needed.

	Procedure	Date (Approximate)	Surgeon
1.			
2.			
3.			
4.			

Please list ALL medications, including non-prescription/supplements. Use back if needed.

	Name	Dose	Frequency		Name	Dose	Frequency
1.				**5.**			
2.				**6.**			
3.				**7.**			
4.				**8.**			

Preferred Pharmacy _____ **Phone number** (____)_____-_____

Are you currently receiving treatment at a pain clinic? ☐ Yes ☐ No

If yes, list name and phone number_____

Please list ALL medical allergies and reaction. ☐ None Latex Allergy ☐ Yes ☐ No

1. _____ **3.** _____

2. _____ **4.** _____

Do you have a living will? ☐ Yes ☐ No Highest grade completed _____

How much caffeine do you drink per day? _____

Stairs in home: ☐ Yes ☐ No Cane: ☐ Yes ☐ No Walker: ☐ Yes ☐ No Wheelchair: ☐ Yes ☐ No

Alcohol use: ☐ Yes ☐ No Number of drinks: ____ day _____week

Tobacco use: ☐ Yes ☐ No _____Cigarettes (pack/day) _____cigars/pipe per day _____dip/chew per day

FACULTY PHYSICIANS KNOXVILLE

Family History (Check all that apply)

☐ Birth Defects	☐ Heart Disease	☐ Blood clots/bleeding problems
☐ High Blood Pressure	☐ Kidney Disease	☐ Cancer
☐ Asthma	☐ Stomach/Colon disease	☐ HIV/AIDS
☐ Emphysema	☐ Seizures	☐ Hepatitis
☐ Diabetes	☐ Stroke	☐ Other _____

Work

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Type of work performed _____

Review of Systems – Have you had an RECENT problems with any of the following?

Constitutional	**Yes**	**No**
Recent Fever	☐	☐
Night Sweats	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
Exercise Intolerance	☐	☐

Genitourinary	**Yes**	**No**
Urinary Incontinence	☐	☐
Difficulty Urinating	☐	☐
Blood in Urine	☐	☐
Urinary Frequency	☐	☐
Incomplete Emptying	☐	☐

Endocrine	**Yes**	**No**
Fatigue	☐	☐
Increased Thirst	☐	☐
Hair Loss	☐	☐
Increased hair growth	☐	☐
Cold Intolerance	☐	☐

Eyes	**Yes**	**No**
Dry Eyes	☐	☐
Irritation	☐	☐
Vision Change	☐	☐

ENMT	**Yes**	**No**
Difficulty Hearing	☐	☐
Ear Pain	☐	☐
Frequent Nose Bleeds	☐	☐
Nose/Sinus Problem	☐	☐
Sore Throat	☐	☐
Bleeding Gums	☐	☐
Snoring	☐	☐
Dry Mouth	☐	☐
Mouth Ulcers	☐	☐
Oral Abnormalities	☐	☐

Musculoskeletal	**Yes**	**No**
Muscle Aches	☐	☐
Muscle Weakness	☐	☐
Joint Pain	☐	☐
Back Pain	☐	☐
Extremity Swelling	☐	☐

Integumentary	**Yes**	**No**
Abnormal mole/lesion	☐	☐
Jaundice	☐	☐
Rash	☐	☐
Itching	☐	☐
Dry skin	☐	☐

Neurologic	**Yes**	**No**
Loss of consciousness	☐	☐

Allergic/Immunologic		
Runny Nose	☐	☐
Sinus Pressure	☐	☐
Itching	☐	☐
Hives	☐	☐
Frequent Sneezing	☐	☐

Notes:

FACULTY PHYSICIANS KNOXVILLE

Teeth Problems	☐	☐	Weakness	☐	☐
			Numbness	☐	☐
Cardiovascular	**Yes**	**No**	Seizures	☐	☐
Chest Pain at rest	☐	☐	Dizziness	☐	☐
Chest pain with exertion	☐	☐	Headaches	☐	☐
Arm pain on exertion	☐	☐	Restless Legs	☐	☐
Short of breath - walking	☐	☐			
- lying down	☐	☐	**Psychiatric**	**Yes**	**No**
Heart Palpitations	☐	☐	Depression	☐	☐
			Sleep Disturbances	☐	☐
Gastrointestinal	**Yes**	**No**	Safe in Relationship	☐	☐
Abdominal Pain	☐	☐	Alcohol Abuse	☐	☐
Vomiting	☐	☐			
Vomiting blood	☐	☐	**Hematologic/ Lymphatic**	**Yes**	**No**
Change in appetite	☐	☐	Swollen Glands	☐	☐
Black/tarry stool	☐	☐	Easy Bruising	☐	☐
Diarrhea	☐	☐	Excessive bleeding	☐	☐

Care Team

Please list any other providers and their specialties who are part of your care team:

Signature_____Date _____