Kara L. Montes D.P.M.

Patient Personal/Medical History

Patient Name: _____ Date of birth: _____ Date: _____

Primary Care Physician:_____ Pharmacy:_____

How did you hear about us? Please let us know: [ ]Dr._____ [ ]Newspaper [ ]Dex Phone Book
[ ]Internet [ ]Friend/Relative [ ]While you Wait Ad [ ]The Local Pages book [ ]SVRHC Guide [ ]Buena Banner
[ ] SV Chamber [ ]Radio Ad [ ]Other:_____

Shoe Size:_____ Height:_____ Weight:_____

Allergies: None Known [ ]
[ ]Penicillin [ ]Morphine [ ]Tape_____ [ ] Sulfa Drugs [ ]Antibiotics_____ _____ [ ]Any foods_____ [ ]Aspirin
[ ]Codeine [ ] Other_____

Medical History: Please indicate if you currently **or** have ever had any of the following.

[ ] **None**	[ ] Diabetes Type 1	[ ] Hepatitis or [ ] Jaundice	[ ] Osteoarthritis
[ ] Acid reflux	[ ] Diabetes Type 2	[ ] High Blood Pressure	[ ] Peripheral Vascular Disease
[ ] Anemia	[ ] Diabetes Neuropathy	[ ] High Cholesterol	[ ] Respiratory Problems
[ ] Arthritis	[ ] Dialysis	[ ] HIV	[ ] Rheumatoid Arthritis
[ ] Asthma	[ ] Epilepsy	[ ] Kidney Disease	[ ] Sickle Cell Disease
[ ] Back Problems	[ ] Fibromyalgia	[ ] Kidney Stones	[ ] Skin Disease:_____
[ ] Bleeding Disorders	[ ] Gastric Ulcers	[ ] Leg or Foot Ulcer/Sore	[ ] Stroke
[ ] Bone/Muscle Problem_____	[ ] Gout	[ ] Liver Disease	[ ] Thyroid Disease
[ ] Cancer (type):_____	[ ] Head/Brain Injury	[ ] Low Blood Pressure	[ ] Tuberculosis
[ ] Circulatory Problems	[ ] Hearing impaired	[ ] Lupus	[ ] Varicose Disease
[ ] COPD	[ ] Hemophilia	[ ] Mental Health Problems	[ ] Venereal Disease
[ ] Currently Pregnant	[ ] Heart Disease	[ ] Multiple Sclerosis	[ ]

Past surgeries: [ ] None [ ] See attached
_____
_____
_____

Social History Occupation:_____
Tobacco Use: [ ] Never [ ] Past [ ]Current-How much?_____
Alcohol Use: [ ] No [ ] Yes If yes [ ] Occasional [ ] Daily
Illicit Drug Use: [ ] Never [ ] Past [ ] Current-What?_____

Family History: (if any family history, please note **who** next to condition)

[ ] No Medical Problems	[ ] Diabetes	[ ] Leg or Foot Ulcers
[ ] Don't know	[ ] Gout	[ ] Liver Problems
[ ] Arthritis	[ ] Heart Disease	[ ] Respiratory Problems
[ ] Cancer	[ ] High Blood Pressure	[ ] Stroke
[ ] Circulatory Problems	[ ] Kidney Problems	[ ] Sickle Cell Disease

Current medications: [ ] None [ ] See attached

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Name: _____ Date of birth: _____ Date: _____

Review of systems: Please check items in each category that **PRESENTLY** apply to you.

General	Eyes	Musculoskeletal	Hematologic
[ ]Fatigue [ ]Fever [ ]Night Sweats [ ]Recent Weight change [ ]Other	[ ]Eye strain [ ]Eye pain [ ]Vision problem [ ]Other	[ ]Frequent sprains [ ]Joint pain [ ]Muscle pain [ ]Stiffness [ ]Other	[ ]Take aspirin [ ]Take Coumadin [ ]Other
Ears, Nose and Throat	**Genitourinary**	**Cardiovascular**	**Neurological**
[ ]Breathing difficulty [ ]Ear discharge [ ]Ear pain [ ]Hearing loss [ ]Hoarseness [ ]Nose bleeding [ ]Nose discharge/obstruction [ ]Nose pain [ ]Sore gums [ ]Sore throat [ ]Other	[ ]Bladder trouble [ ]Blood in urine [ ]Difficulty urinating [ ]Discolored urine [ ]Excessive urination [ ]Frequency of urination [ ]Painful urination [ ]Prostate problems [ ]Other	[ ]Chest pain [ ]Circulatory problems [ ]Heart Attack [ ]Heart problems [ ]Pain over heart [ ]Rapid heart beat [ ]Tiredness [ ]Varicose veins [ ]Weakness [ ]Other	[ ]Confusion [ ]Convulsions [ ]Dizziness [ ]Fainting [ ]Headaches [ ]Loss of feeling [ ]Muscle jerking [ ]Numbness [ ]Tingling in legs/feet [ ]Other

Gastrointestinal		Respiratory	Skin
[ ]Abdominal pain	[ ]Indigestion	[ ]Coughing blood	[ ]Abrasions
[ ]Belching	[ ]Nausea	[ ]Coughing phlem	[ ]Bruises
[ ]Black stool	[ ]Poor appetite	[ ]Difficulty breathing	[ ]Discolorations
[ ]Bloody stool	[ ]Stomach trouble	[ ]Lung problems	[ ]Hives
[ ]Constipation	[ ]Vomiting	[ ]Persistent cough	[ ]Itching
[ ]Diarrhea	[ ]Other	[ ]Shortness of breath	[ ]Moles
[ ]Difficulty swallowing		[ ]Wheezing	[ ]Poor wound healing
[ ]Gas		[ ]Other	[ ]Skin rash
[ ]Hemorrhoids			[ ]Sores
			[ ]Other

What is your main foot complaint? _____

Have you ever had a foot/ankle surgery? [ ] YES [ ]NO

If yes, what was the surgery?_____

Who was your foot doctor?_____

Responsible party signature: **Date:**

_____ _____

Relationship to patient: [ ] SELF [ ] POA [ ] PARENT [ ]other_____

Name:_____