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PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE: _____
LAST FIRST MIDDLE

To help us adequately meet all of your podiatric needs, please complete the answers to the following questions:
 PLEASE LIST ALL ALLERGIES (INCLUDING ALLERGIES TO DRUGS/MEDICATIONS):

PLEASE LIST ALL MEDICATIONS, INCLUDING NON-PRESCRIPTION MEDICATIONS, THAT YOU ARE CURRENTLY TAKING AND THE DOSAGE:

FAMILY HISTORY:

In your family, is there a history of:	WHO?		WHO?
<input type="checkbox"/> HEART DISEASE	_____	<input type="checkbox"/> KIDNEY DISEASE	_____
<input type="checkbox"/> HIGH BLOOD PRESSURE	_____	<input type="checkbox"/> OSTEOPOROSIS	_____
<input type="checkbox"/> STROKE	_____	<input type="checkbox"/> EPILEPSY	_____
<input type="checkbox"/> CANCER (OF WHAT?)	_____	<input type="checkbox"/> THYROID PROBLEMS	_____
<input type="checkbox"/> DIABETES MELLITUS	_____		

Do you drink alcoholic beverages on a regular basis? Yes No If yes, how much and how often?

Do you smoke? Yes No If yes, how much per day? _____

Do you have any of the following?

(PLEASE INDICATE WITH A CHECK MARK) YES NO

Extreme Fatigue YES NO

EYES

Recent eye Injury YES NO

Blurred or Double Vision YES NO

New Onset Glaucoma YES NO

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing YES NO

Earaches or Drainage YES NO

Sore Throat YES NO

CARDIOVASCULAR

Chest Pain or Discomfort YES NO

Known Heart Problems YES NO

Shortness of Breath YES NO

High Blood Pressure YES NO

Circulation Problems YES NO

Ankle or Leg Swelling YES NO

Leg Pain while Walking YES NO

Cramps in Feet/Legs YES NO

RESPIRATORY

Frequent Cough YES NO

Spitting up Blood YES NO

Wheezing YES NO

GASTROINTESTINAL

Nausea or Vomiting YES NO

Change in Bowel Movmts. YES NO

Rectal Bleeding YES NO

GENITOURINARY

Frequent Urination YES NO

Incontinence or Dribbling YES NO

NEUROLOGICAL

Loss of Balance YES NO

Headaches YES NO

Dizziness YES NO

Numbness YES NO

OTHER

Slow to Heal after Cuts YES NO

Diabetes YES NO

Asthma YES NO

Arthritis YES NO

Gout YES NO

Kidney Problems YES NO

Phlebitis YES NO

Pain in Joints YES NO

Skin Problems YES NO

Ulcers YES NO

(Continued on Back)

If you have answered yes to any of the symptoms/medical problems on the front side, please indicate the symptom/medical problem and explain:

If you have diabetes, please list your diabetic doctor and the date of your last visit.

Doctor's name: _____ Address: _____

Date of last visit: _____

Please list any major surgeries and the date that they were performed.

Please list any other podiatric problems or concerns that you may have.

To the best of my knowledge, I have accurately and completely answered the questions on this form regarding my health. I understand that providing incorrect information to my physician can be dangerous to my health. I also understand that it is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff of Aesthetic & Family Podiatry Center to perform the necessary services that I may need.

SIGNATURE OF PATIENT OR GUARDIAN

DATE

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits to the provider of the medical services performed on my behalf. (Lifetime Signature)

SIGNATURE OF PATIENT OR GUARDIAN

DATE