NEW PATIENT MEDICAL HISTORY

Name_____ Date of Birth _____ Today's Date _____

Who referred you to us? _____

Primary Care Provider: _____

Reason for Today's Visit: _____

Preferred Pharmacy: _____

Allergies: _____

Past Medical History (please check all that apply)

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Venous Disease/Stasis
- ☐ Lymphedema
- ☐ Lupus
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Pacemaker / Defibrillator
- ☐ Pacemaker / Defibrillator
- ☐ Blood Clots – Where? _____
- ☐ Stroke
- ☐ HIV / AIDS
- ☐ Hepatitis- What kind?_____
- ☐ Asthma
- ☐ COPD
- ☐ Seizures
- ☐ Cancer- What kind?_____
- ☐ Thyroid Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____
- ☐ _____

Surgical History

Name of Surgery	Date of Surgery	Surgeon

Family History (check all that apply)

Conditions:	Mother	Father	Maternal Grandparent	Paternal Grandparent	Sibling	Child
Diabetes						
Heart Disease						
High Blood Pressure						
Lupus						
Kidney Disease						
Lung Disease						
Unknown History						

Social History:

Are you married, single, divorced or separated? _____

Who lives at home with you? _____

Are you currently employed? _____ If so, what do you do for work?_____

Do you use tobacco products? _____ What kind of tobacco? _____

How many cigarettes per day? _____ How long have you used tobacco? _____

If you quit using tobacco, when did you quit? _____

Do you drink alcohol? _____ How many drinks per day? _____

Do you use any drugs? If so, which ones? _____

Do you have home health? If so, which company? _____

Review of Systems

Please check any symptoms that you are **currently experiencing** or have experienced in the **last 2 weeks**.

Constitutional:
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Changes
- ☐ Glasses/Contacts
- ☐ Vision Changes

Respiratory:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Oxygen Use

Cardiac:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg pain at rest
- ☐ Leg pain with activity
- ☐ Swelling in legs
- ☐ Difficulty breathing when lying flat

GI:
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Trouble Swallowing

Skin:
- ☐ Rash
- ☐ Changes in skin color
- ☐ Ulcers
- ☐ Prone to skin tears
- ☐ Calluses / Corns
- ☐ Changes in hair/skin/nails.

Musculoskeletal:
- ☐ Decreased activity level
- ☐ Use of a walker / cane / wheelchair

Neurological:
- ☐ Abnormal Gait
- ☐ Numbness
- ☐ Tingling
- ☐ Pain from Neuropathy
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizures

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Suicidal thoughts

Hematologic:
- ☐ Problems with bleeding or clotting
- ☐ Easy bruising
- ☐ Taking a blood thinner

History of Current Wound(s):

What caused your wound? _____

How long have you had it? _____

What have you treated it with?_____

Are you currently taking antibiotics for your wound? ___ _____

Have you had a recent X-ray, MRI, or cat scan for the wound?_____

When & Where? _____

What did it show? _____

What other things have you done (if anything) to help make the wound better?

_____

Please list all your medications, dosages, and how you take them:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you agree to participate in medication history retrieval if we need to request information from your pharmacy? Yes _____ No _____