

ENCINITAS PODIATRY GROUP

James P. Hatfield, DPM inc

S. Luke Berthelsen, DPM

501 North El Camino Real, Suite 201

Encinitas, California 92024

760.436.8667

PAST MEDICAL HISTORY

NAME _____ **DATE OF BIRTH:** _____ **DATE:** _____

How did you hear of our office? _____ **Relationship:** _____

Primary Care Physician: _____ **Specialist:** _____

Previous Podiatrist: _____ **PLEASE MARK NO IF NO CONDITION IS CIRCLED IN A SECTION**

CARDIOVASCULAR (please circle) **NO CARDIOVASCULAR PROBLEMS**

- | | | | |
|------------------|---------------------|--------------------------------|----------------------------------|
| Heart Attack | Angina (Chest Pain) | Rheumatic Fever | Palpitations |
| Heart Murmur | Heart Failure | Heart Disease | Mitral Valve Prolapse |
| Heart Surgery | Pacemaker | Hypertension | Anti-Coagulant Medication |
| Vascular Disease | Vascular Surgery | Deep Vein Thrombosis/Phlebitis | |
| Bruise Easily | Bleed Easily | Reynaud’s Syndrome | |

NEUROLOGICAL (please circle) **NO NEUROLOGICAL PROBLEMS**

- | | | | |
|-----------------------|------------------------------|------------------------------|----------------------|
| Stroke | Epilepsy /Seizures | Mental Disorders | Depression |
| Peripheral Neuropathy | Reflex Sympathetic Dystrophy | Loss of Sensation / Numbness | Dementia/Alzheimer’s |
| Parkinson’s Disease | | | |

GASTROINTESTINAL (please circle) **NO GASTROINTESTINAL PROBLEMS**

- | | | | | |
|---------------------|---------------|--------------------|---------------|-----------|
| Gastric Reflux-GERD | Stomach Ulcer | Intestinal Disease | Liver Disease | Hepatitis |
|---------------------|---------------|--------------------|---------------|-----------|

MUSCULOSKELETAL (please circle) **NO MUSCULOSKELETAL PROBLEMS**

- | | | | | |
|---------------|--------------------------------------|-------------------|----------|------|
| Arthritis | Rheumatoid Arthritis | Artificial Joints | Sciatica | Gout |
| Back Problems | Implants in the Body (where?): _____ | | | |

SKIN (please circle) **NO SKIN PROBLEMS**

- | | | | | |
|-----------|---------------|--------------------------|-------------|--------|
| Psoriasis | CRST Syndrome | Venous Dermatitis – Legs | Skin Cancer | Eczema |
|-----------|---------------|--------------------------|-------------|--------|

ENDOCRINE (please circle) **NO ENDOCRINE PROBLEMS**

- | | | |
|------------------|--|--|
| Thyroid Problems | Diabetes, SELF: (Type I or Type II) | Diabetes in Family (who?) _____ |
|------------------|--|--|

OTHER (please circle) **NO OTHER PROBLEMS**

- | | | | |
|--------------------|----------------|--------------------------|------------------|
| Cancer _____ | Glaucoma | Kidney Disease | Lupus |
| Current Infections | MRSA Infection | Allergies / Hives | Organ Transplant |
| Venereal Disease | AIDS / HIV | Drug / Alcohol Addiction | |

PLEASE LIST IF NOT LISTED ABOVE: _____

CURRENT MEDICATIONS (please circle) **NOT TAKING ANY MEDICATIONS**

- | | | | | | | | |
|-----------------------------------|--------------------|-----------------------|-----------------------------------|---------------|----------------|---------------|----------------|
| Anti-Coagulant Medication: | Aggenox | Aspirin | Coumadin (Warfarin) | Plavix | Pradaxa | Ticlid | Xarelto |
| Anti-Inflammatory Medication | Antibiotics | Arthritic Medications | Prednisone / Cortisone Medication | | | | |
| Immunosuppressive Medications | Statin Medications | Thyroid Medications | Vitamin E | | | | |

Other Medication (please list): _____

ALLERGIES (please circle) **NO KNOWN ALLERGIES**

- | | | | |
|-------------|-------------|---------------|----------|
| Aspirin | Penicillin | Codeine | Vicodin |
| Demerol | Antibiotics | Sulfa Drugs | Novocain |
| Anesthetics | Iodine | Adhesive Tape | Latex |

Other Allergies (please list): _____

SOCIAL Do you drink alcohol? YES NO # Glasses/Week _____ Do you Smoke? YES NO Cigarettes/Day _____

WOMEN Are you pregnant? YES NO If yes, which month? ____ Are you nursing? YES NO

I certify that the above information is COMPLETE and ACCURATE.

PATIENT’S OR REPRESENTATIVE’S PRINTED NAME

RELATIONSHIP

PATIENT’S OR REPRESENTATIVE’S SIGNATURE

DATE