Medical History Form **Office of Jeffrey V. Chou, DPM**

First Name ___________________________ M.I._______ Last Name_______________________________

Date of Birth ___________________ Height ______________ Weight _______________________________

Most Current Blood Pressure __________________ Date of Last Flu Shot ____________________________

Where did you receive the flu shot?_____________________ Date of Last Pneumonia Shot _______________

What brings you into the office today?

____

____

When does this problem occur?

____

Any previous treatments for the issue? (Either prescribed or Home Remedies)

____

Is it a work-related injury? ________________________ If Yes, date of injury? ________________________

List any current sports / activities ____

Are you on a blood thinner? ______________________ If so WHY ?__________________________________

List below or attach a current list of medications (prescription and over-the-counter)?

____

____

____

Allergies? ____

Please list hospitalizations:

____

____

MEDICAL HISTORY (Please Circle All That Apply)

Alcohol/Drug addiction
Alzheimers/Dementia
Anemia - Type ______________________
Arrhythmias - Type __________________
Arthritis
Asthma
Bleeding/Clotting problem
Cancer-Type __________
Depression / Anxiety / Bipolar
Diabetes: Insulin Dependent or Non Insulin Dependent
How long? (years)__________
Last A1C________________
Last FBS________________
Emphysema/COPD
GERD (Reflux)
GI ulcers
Gout
Headaches / Migraines
Heart Disease
Hepatitis A B or C/Liver Disease
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney/Renal Failure
Lung Disease/Pulmonary Embolus
Osteoporosis/Osteopenia
Phlebitis (blood clots in legs)
Pregnancy- If yes, due date____________
Poor Circulation/PVD
Seizures/Epilepsy
Sickle Cell Trait/Disease
Thyroid Problems

Please list other medical problems not listed:

____

Surgical History (List surgeries you have had in the last 7 years):

____

CIGARETTE SMOKING: (circle) 1. Never Smoked 2. Quit: former smoker 3. Smokes less than daily
4. Smokes daily – if yes, how many? ____________________________

OTHER NICOTINE (e-cigs, snuff, chew, dip) ____

ALCOHOL: YES or NO If YES, how many drinks consumed in a day? _________ Week? _________

Do you or have you used illicit/recreational drugs? YES or NO If yes which ones____________________

Consent for Treatment: I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any questions on the form I should ask the doctor or a member of the office staff for assistance. By signing below, I hereby authorize Jeffrey V. Chou, DPM to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give permission to Jeffrey V. Chou, DPM to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet, ankles, and lower legs.

Signature of Responsible Party ____________________________________ Date ____________________

Relationship (if not Patient) ____