PREMIER *medical group*

Patient Name _____ Date of birth _____

Medical History

Primary Care Physician_____ Date of last visit _____
Pharmacy name and location _____
Former foot doctor_____
Previous foot care_____
Explain your foot/ankle problem_____

Please circle any symptoms in feet:

Burning Numbness Sharp Other_____

Circle pain level (10 being worst) 1 2 3 4 5 6 7 8 9 10

When did pain/discomfort begin? _____
What makes pain/discomfort better? _____
What makes pain/discomfort worse? _____
If condition has been treated, explain _____

Social History:

Height _____ Weight_____ Shoe size_____ Are you pregnant? _____ Nursing?_____
Do you have diabetes? _____ Are you insulin dependent? _____ Last A1C _____ Date of last A1C _____
Do you use tobacco? _____ How often? _____ Former smoker quite date _____
Do you use: Alcohol _____ Caffeine_____ Illegal drugs_____

List all medication names, doses & frequency (Attach list if possible)

_____
_____
_____

List all allergies (including environmental, adhesive, drug)_____
_____

List all surgeries and dates performed _____
_____

Family History Circle all that apply and whom it applies to.

Diabetes	mother/father	Heart disease	mother/father	Bleeding disorder	mother/father
Mental illness	mother/father	Stroke	mother/father	High blood press.	mother/father
Kidney disease	mother/father	Cancer	mother/father	Arthritis	mother/father

Other _____
_____ NONE OF THE ABOVE

Leonard S. Gerber, DPM and Christopher Bromley, DPM, PC

***Please note your insurance company/government requires you to check YES or NO to each box ***

Please check if you currently have or have a recurring history of the conditions listed below:

Constitutional Symptoms:	YES	NO	Gastrointestinal:	Yes	No
Chills			Stomach Ulcers		
Sweats			Nausea		
Weight Loss			Vomiting		
Fevers			Diarrhea		
Other:			Constipation		
Head, Eyes, Ears, Nose and Throat:			Heartburn		
Wear: Contacts/Eyeglasses			Blood in Stool		
Glaucoma			Hepatitis		
Double Vision			Acid Reflux		
Dizziness			Irritable Bowel Syndrome:		
Cataracts			**Endocrine:**		
Nose Bleeds			Often: Thirsty/Urination		
Ringing in Ears			Hypoglycemia		
Difficulty Swallowing			Kidney Disease		
Other:			Premenopausal symptoms		
Cardiovascular:			Thyroid Disorder: Hyper/Hypo ***PLEASE CIRCLE ONE***		
Phlebitis			High Cholesterol		
High Blood Pressure			Gout		
Chest Pain/Heart Attack/ Cardiovascular Sx			**Musculoskeletal:**		
Congestive Heart Failure			Tendonitis / Bursitis		
Heart Murmur			Arthritis		
Palpations			Broken Bones:_____		
Mitral Valve Prolapse			Joint: Pain/Swelling		
Swelling in Legs/Ankles			Other:		
Leg Pain/Cramping			**Nervous System:**		
Other:			Migraines		
Hematological/Lymphatic (blood):			Seizures		
Prolonged: Healing/Bleeding			Strokes		
Anemia			Ataxia (loss of balance)		
Lump in Groin or behind knee			Numbness: tingling/loss of sensation: Where:_____		
Lymphoma			Neuropathy (loss of sensation)		
Swollen Gland			Other:		
Bruise easily			**Skin Conditions:**		
HIV/AIDS			Rash		
Respiratory:			Sensitivity to Sun		
Shortness of Breath			Skin Ulcers		
Emphysema			Keloid (scarring)		
Cough			Contact Dermatitis		
Bronchitis			Growth on Skin		
Difficulty Breathing			Recurrent Infections		
Asthma			Cracking of the Skin		
Previous Pulmonary Disease			Eczema/Dermatitis/Psoriasis		
Pneumonia			**Genitourinary:**		
TB (tuberculosis) exposure/treatment			Urination: Painful/Bloody		
Other:			STD's: _____		
Psychiatric: *History of...*			Dialysis		
Nervousness			Other:		
Tension			**Other:**		
Depression			Cancer: Type _____		
Anxiety			Lyme Disease		

) the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to y health.

tient/Guardian Signature: _____ Date: _____