Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY - PODIATRY

Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT TODAY

What is the reason for your visit today? _____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years Result of accident or work injury? ☐ Yes ☐ No

What treatments have you tried and have they been effective?

On a scale of 1 – 10 (1 being no pain and 10 being the worst), what is your level of pain? ____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling Other: _____

VITAL SIGNS

Blood Pressure: _____/ _____ Height: _____ Weight: _____lbs

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ No Known Allergies		☐ No Known Drug Allergies	
☐ Aspirin		☐ Latex	
☐ Doxycycline		☐ Other:	
☐ Erythomycin		☐ Other:	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

VACCINES (Please check all vaccines that you have had & the date in which the vaccine was given)

Vaccine	**Date**	**Vaccine**	**Date**	**Vaccine**	**Date**
☐ Hepatitis A				☐ Influenza	
☐ Hepatitis B				☐ Tetanus	
☐ Other	:			☐ Other:	

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*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY PC

SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer Not to Discuss

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Illicit Drugs: _____

Seat belts used routinely: ☐ Yes ☐ No Sunscreen used routinely: ☐ Yes ☐ No

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Alcoholism	☐ Depression	☐ Mental Illness
☐ Allergies	☐ Diabetes (Type1, Type 3)	☐ Musculoskeletal
☐ Anxiety Disorder	☐ Gout	☐ Neuropathy *(specify)*
☐ Arthritis *(specify)*	☐ Heart Disease	☐ Skin Disorders
☐ Asthma	☐ Heart Murmur	☐ Sleep Apnea
☐ Blood Clot	☐ Hepatitis	☐ Stomach/Bowel Disorder
☐ Blood Disorders	☐ HIV	☐ Stroke
☐ Breathing Issues	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ High Cholesterol	☐ Other:
☐ Circulation Problems	☐ Kidney Disease	☐ Other:
☐ CVA	☐ Liver Disease	
Are you pregnant? ☐ Yes ☐ No	Are you nursing? ☐ Yes ☐ No	

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ None		☐ Cardiac Surgery	
☐ Angioplasty		☐ Cataract Surgery	
☐ Appendectomy		☐ Cholecystectomy	
☐ Arthroscopic Surgery		☐ Foot/Ankle Surgery	
Where?		Where?	
☐ Artificial Heart Valve		☐ Joint Replacement	
☐ Bypass		Where?	
☐ Caesarean Section		☐ Knee Surgery	
☐ Cancer Surgery		☐ Other	
☐ Cardiac Catheterization		☐ Other	
		☐ Other:	
		☐ Other:	

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Allergy			
☐ Alzheimer's Disease			
☐ Anemia			
☐ Angina (Heart Problems)			
☐ Anxiety Disorder			
☐ Arthritis			
☐ Asthma			
☐ Blood Clot			
☐ Cancer			
☐ Cataracts			
☐ Circulation problems			
☐ Coronary Artery Disease			
☐ Deep Venous Thrombosis (DVT)			
☐ Depressive Disorder (Depression)			
☐ Diabetes			
☐ Disease of Liver (Liver Problems)			
☐ Emphysema			
☐ Heart Disease			
☐ Neurological			
☐ Stroke			
☐ Other:			
☐ Other:			