West Michigan Foot and Ankle PLLC
Alexus Squires DPM, AACFAS

# New Patient History Form

Patient First Name: _____ Patient Last Name: _____

Height: _____ Weight:_____ Pain Level (0-10): _____

## ALLERGIES

_____No known drug allergies **OR**
Please list any allergies with reaction below:

| Drug/Environmental/Food Allergy: | Reaction: |
|---|---|
| | |
| | |

## MEDICATIONS

Please list all medications and dosages:

| | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**PERSONAL MEDICAL HISTORY** Check those that apply to you now or have applied to you in the past:

| | | | |
|---|---|---|---|
| | Frequent Headache/Migraines | | Anemia/Blood Disorders |
| | Liver Disorder | | Pneumonia |
| | Kidney Disease | | Drug/Alcohol Abuse |
| | Dialysis | | Epilepsy or Seizures |
| | Diabetes Average Blood Sugar _____<br>Last A1C_____ | | Stomach/Ulcer Disorder |
| | Asthma | | Thyroid/Parathyroid Disease |
| | Emphysema | | High Blood Pressure |
| | Heart Trouble | | Arthritis |
| | Stroke | | Psychiatric Treatment |
| | Chest pain on mild exertion | | Sexually Transmitted Disease |
| | Gout | | Difficulty Healing |
| | Blood clots | | Hepatitis/HIV |
| | Ear, Nose, Throat Disorder | | |
| | Other | | |

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## SURGICAL HISTORY

| Surgical Procedure | Year | Physician | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

Has any **family member** had any of the following (please indicate relationship)

| | |
|---|---|
| Cancer: | Diabetes: |
| Heart Trouble: | High Blood Pressure: |
| Kidney Disease: | Bleeding Disorders: |
| Stroke: | Blood Clots: |
| Arthritis: | Other: |

## SOCIAL HISTORY

Do you smoke currently? Yes ⬜ No ⬜ If yes, how much per day? _____

Do you drink alcohol? Yes ⬜ No ⬜ If yes, what and how often? _____

Do you use recreational drugs? Yes ⬜ No ⬜

## Are you currently experiencing any of the following? Check all that apply:

**Constitutional:** ⬜ Weight Loss ⬜ Fever /Chills

**Eyes:** ⬜ Visual changes

**Ears, Nose, Mouth, and Throat:** ⬜ Hearing loss

**Cardiovascular:** ⬜ Chest pain ⬜ Varicose veins ⬜ Peripheral edema.

**Respiratory:** ⬜ Cough ⬜ Shortness of Breath ⬜ Wheezing

**Gastrointestinal:** ⬜ Abdominal pain ⬜ Heartburn

**Genitourinary:** ⬜ Frequent urination

**Musculoskeletal:** ⬜ Joint ⬜ Pain ⬜ Swelling

**Integumentary:** ⬜ Rashes ⬜ Sores ⬜ Blisters

**Neurological:** ⬜ Numbness ⬜ Tingling ⬜ Burning

**Psychiatric:** ⬜ Anxiety ⬜ Depression

**Endocrine:** ⬜ Heat/cold intolerance

**Hematologic/Lymphatic:** ⬜ Abnormal bleeding

**Allergic/Immunologic:** ⬜ Recurrent infections