Gilbert Podiatry Associates, P.C.

Barbara A. Davis, D.P.M

Medical History Form

Name:___________________________________ Age:__________ Date of Birth:____________________

Medications and dosages:

___________________________ ___________________________ ____________________________

___________________________ ___________________________ ____________________________

___________________________ ___________________________ ____________________________

Allergies:

___________________________ ___________________________ ____________________________

Past Medical History

Do you have or have you had any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout	Bladder Problems
Neurological Disorders	High Blood Pressure	Urinary Tract	Infections	Stomach Ulcers
Stroke	Liver Disease	Heart Attack	Hepatitis	Tuberculosis
Thyroid Problems	Heart Disease	Emphysema/COPD	Pacemaker	Asthma
Congestive Heart Failure	Diabetes	Depression	Anxiety	HIV/AIDS
High Cholesterol	Osteoporosis	Psychiatric Disorder	Arthritis	Headaches
Rheumatoid Arthritis	Lyme Disease	Childbirths	Alcoholism	Addiction

Other:____

Surgical History

Have you had any of the following surgical procedures? (Please circle and include date)

Back Surgery____________________________ Neck Surgery_____________________________________

Knee Surgery____________________________ Shoulder Surgery________________________________

Heart Surgery____________________________

Other Hospitalizations and/or procedures: -

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_______________________” ____

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Family History

Does anyone in your family suffer from any of the following medical conditions? (Please circle)

Cancer	Kidney Disease	Blood Disorders	Gout	Bladder Problems
Neurological Disorders	High Blood Pressure	Urinary Tract	Infections	Stomach Ulcers
Stroke	Liver Disease	Heart Attack	Hepatitis	Tuberculosis
Thyroid Problems	Heart Disease	Emphysema/COPD	Pacemaker	Asthma
Congestive Heart Failure	Diabetes	Depression	Anxiety	HIV/AIDS
High Cholesterol	Osteoporosis	Psychiatric Disorder	Arthritis	Headaches
Rheumatoid Arthritis	Lyme Disease			

Other:____

Social History

Social History: Do you Smoke? YES or NO Packs per day ____________________________________

Do you drink alcohol? YES or NO Drinks per week __________________________________

Do you use street Drugs? YES or NO

Occupation: Are you working? YES or NO Job Description __________________________________

Company ____

_____________________________________ _____________________________

Signature of Patient or Guarantor Date