Chart No:

ALL FLORIDA PODIATRY, P.A.

MARC G. COLALUCE, D.P.M.

Please PRINT Clearly; No Cursive.

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date:** _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F

1.) New Patient Established Patient 2.) Vitals to Be Taken From Medical Assistant MU

3.) Primary Doctor: _____ MD DO Last Date Seen: ___/____/_____

4.) **Chief Complaint & Historical Patient Information:**

a. Why Are You Here Today? _____

b. When Did This Problem Start? _____

c. What Is Your Pain Level 1-10 (10 Being The Highest): _____

d. Does Your Primary Doctor Examine Your Feet? Yes No

e. Are You Currently Participating In Physical Or Occupational Therapy? Yes No

i. If Yes, When Did You Receive Therapy? _____

ii. If Yes, Where Did You Receive Therapy? _____

f. Have You Seen A Podiatrist Before? Yes No

i. If Yes, Please Give The Doctor's Name: _____

g. Have You Had A Pedicure Before at a Spa/Salon Before? Yes No

i. If Yes, When? _____

ii. If Yes, Where? _____

h. Are You Currently Using Any Device to Assist Walking or Standing? Yes No

i. Please Check Which Device(s):

1. Leg Brace(s)
2. Cane/Staff
3. Walker
4. Wheelchair
5. Other:_____ FF

Chart No:

5.) **Past Medical History:**

Please Check If You Have, Or Had Had In The Past, Any Of The Following:

Diabetes
Type I
Type II
Arthritis
Poor Circulation
Low Back Pain
Stroke
Anemia
Gout

Asthma
Liver Disorder
Kidney Disease
Keloids/ Thick Scars
Heart Disease
Lung Disorder
Rheumatism
Ulcers

High Blood Pressure
Bleeding Problems
Broken Bones
Which Bones: _____

Other: _____FF

6.) **Past Surgical History:**

a. Previous Injuries: _____ Date: ____/_____/_____

b. Previous Surgeries:_____ Date:____/_____/_____

c. Previous Hospitalizations:_____ Date: ____/_____/_____

7.) **List of Current Medications With Dosages:**

If You Have A List, Please Turn It In To The Front Desk With This Paperwork.

_____Date Began: ___/__/____ _____Date Began: ___/__/____

_____Date Began: ___/__/____ _____Date Began: ___/__/____

_____Date Began: ___/__/____ _____Date Began: ___/__/____

_____Date Began: ___/__/____ _____Date Began: ___/__/____

8.) **Family History: Please Check Any of The Following That Apply**

	Mother Has/Had	Father Has/Had	Both Parents Have/Had
Diabetes			
Arthritis			
Heart Disease			
High Blood Pressure			
Cancer			

Mother's:
Date of Birth:___/___/_____
Date Passed: ___/___/_____

Father's:
Date of Birth:___/___/_____
Date Passed: ___/___/_____

9.) **Personal/Social History:**

Please Check The Boxes That Apply:

a. **Smoking**: MU

- Never
- Former; Date You Quit Smoking: ___/___/_____
- Former, Current Status Unknown
- Current Smoker, Some Days
- Current Smoker, Everyday
- Unknown

If you are a Current Smoker, Please Fill In the Fields Below:

No. of Cigarettes per Day? _____

How Many Years Have/Had You Been Smoking? _____

Type of Tobacco/Nicotine Used:

- Cigarettes
- Cigars
- Pipe
- Chewing Tobacco
- E-Cigarette

b. **Alcohol Intake**:

- Denies Alcohol Use
- Drinks Rarely
- Drinks Socially
- Drinks Daily
- Abusive Drinker
- Abusive Drinker, Not Now

c. **Caffeine Intake**:

- Denies
- Rarely
- Occasionally
- Daily
  - Coffee
  - Caffeinated Soda
  - Tea

d. **Marital Status**:

- Single
- Partnership

e**. Sexual Activity**: Yes No

If You Are A Female, Are You Now Pregnant? Yes No MU

g. **Race**: MU

- White
- American Indian/Alaska Natives
- Black/ African American
- Native Hawaiian/ Pacific Island American

Ethnicity: MU

Hispanic or Latino

OR

Non-Hispanic or Latino

h. **Language**: MU

- English
- Spanish
- French
- Russian
- Dutch
- Italian
- German
- Chinese
- Japanese
- Other: _____

Chart No:

10.) **Allergies:** FF

Mark All Allergies and/ Reactions:

Adhesive Tape/_____	Contrast Dye/Iodine/ _____
Metal/_____	Codeine/ _____
Penicillin/ _____	Pollen/ _____
Latex/Natural Rubber/_____	Shellfish/ _____
Aspirin/_____	Local Anesthetics/ _____
Sulfa Drugs/ _____	Other _____/ _____

Pharmacy Name:_____ Phone: _____

Pharmacy Address: _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.
Thank you.

Patient Print Name & Sign: _____

Caregiver Print Name & Sign: _____

Notes for the Doctor: _____

_____.

ALL FLORIDA PODIATRY, P.A.

MARC G. COLALUCE, D.P.M.

Please PRINT Clearly; No Cursive.

PATIENT MEDICAL HISTORY FORM

Name: _____ Date: Click here to enter a date.

Date of Birth: Click here to enter a date. Age: Sex: Choose an item.

1.) New Patient or Established?: Choose an item.

2.) Vitals to be taken by our Medical Assistant. MU

3.) Primary Care Doctor: , MD or DO Last Date Seen by Primary: Click here to enter a date.

1.) WHY ARE YOU HERE TODAY? WHEN DID THIS PROBLEM START? WHAT IS YOUR PAIN LEVEL 1 – 10?

_____
_____
_____
_____

2.) PREVIOUS INJURIES/ SURGERIES/ HOSPITALIZATIONS – DATES OR YEAR?

_____
_____
_____
_____

PLEASE CHECK IF YOU HAVE, OR HAD IN THE PAST, ANY OF THE FOLLOWING:

_____ DIABETES - WHAT TYPE? ____
_____ ARTHRITIS
_____ POOR CIRCULATION
_____ LOW BACK PAIN
_____ STROKE
_____ ANEMIA
_____ GOUT
_____ ASTHMA
_____ LIVER DISORDER
_____ KELOIDS/THICK SCARS
_____ HEART DISEASE
_____ LUNG DISORDER
_____ RHEUMATISM
_____ ULCERS
_____ HIGH BLOOD PRESSURE
_____ BLEEDING PROBLEMS
_____ KIDNEY/LIVER DISORDER
_____ BROKEN BONES –

WHAT BONES? _____
_____

OTHER: _____
_____

3.) LIST CURRENT MEDICATIONS WITH DOSAGES.
IF YOU HAVE A LIST, PLEASE TURN IT IN WITH THIS PAPERWORK.

_____
_____
_____
_____

4.) LIST ALLERGIES WITH REACTIONS:

_____
_____
_____
_____

5.) WHEN YOU HAVE A PHYSICAL EXAMINATION, DOES YOUR PRIMARY PHYSICIAN EXAMINE YOUR FEET? Y N

6.) ARE YOU CURRENTLY PARTICIPATING IN PHYSICAL OR OCCUPATIONAL THERAPY? Y N
IF YES, WHERE? _____

7.) HAVE YOU SEEN A PODIATRIST BEFORE? Y N
IF YES, PLEASE GIVE THE DOCTOR'S NAME: _____

8.) HAVE YOU HAD A PEDICURE BEFORE? Y N
IF YES, WHEN AND WHERE? _____

9.) ARE YOU CURRENTLY USING A WHEELCHAIR OR WEARING LEG BRACES?

_____

FAMILY HISTORY: PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

	MOTHER	FATHER
DIABETES	_____	_____
ARTHRITIS	_____	_____
HEART DISEASE	_____	_____
HIGH BLOOD PRESSURE	_____	_____
CANCER	_____	_____

DATE OF BIRTH _____ DATE OF BIRTH _____
DATE OF DEATH _____ DATE OF DEATH _____

NAME:_____ CHART #_____

SEX: MALE_____ FEMALE_____

SOCIAL HISTORY: PLEASE CHECK THE FOLLOWING THAT BEST DESCRIBES YOU.

_____ MARRIED
_____ SINGLE
_____ DIVORCED
_____ WIDOW

_____ ATHLETIC
_____ SEDENTARY
_____ MODERATELY ACTIVE
WHAT TYPE? _____

RACE:

_____ AMERICAN INDIAN/ALASKA NATIVES
_____ ASIAN
_____ BLACK/AFRICAN AMERICAN
_____ NATIVE HAWAIIAN/PACIFIC ISLAND AMERICAN
_____ WHITE
_____ PATIENT DECLINED

ETHNICITY:

_____ HISPANIC OR LATINO
_____ NON HISPANIC OR LATINO
_____ PATIENT DECLINED

LANGUAGE:

_____ENGLISH _____SPANISH _____FRENCH _____RUSSIAN

_____DUTCH _____ITALIAN _____GERMAN _____CHINESE

_____JAPANESE _____ OTHER

SMOKING:

_____ CURRENT, EVERY DAY
_____ CURRENT, SOME DAYS
_____ FORMER
_____ NEVER
_____ FORMER, CURRENT UNKNOWN
_____ UNKNOWN

WHAT IS YOUR SOURCE? _____
HOW MUCH A DAY & FOR HOW MANY YEARS? _____

NAME: _____ CHART # _____

PLEASE CIRCLE ONE

ALCOHOL INTAKE DAILY – OCCASIONAL – RARELY - NONE
CAFFEINE INTAKE DAILY – OCCASIONAL - RARELY - NONE
WHAT IS YOUR SOURCE? _____

ARE YOU SEXUALLY ACTIVE? YES OR NO

IF YOU ARE FEMALE, ARE YOU NOW PREGNANT? _____

Pharmacy Name_____ Phone_____

Pharmacy Address_____

Notes for the Doctor:

_____

_____

_____

THANK YOU!

NAME:_____ CHART #_____