

**Myers Podiatry, Ltd.**

Please fill out completely and return to the window.

Today's Date: \_\_\_\_\_  
Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_  
Address: \_\_\_\_\_ Spouse: \_\_\_\_\_  
\_\_\_\_\_ If child, Parents: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Responsible Party: \_\_\_\_\_  
Soc. Sec. No. \_\_\_\_\_ Primary Insur: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Pol. No.: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Secondary Insur.: \_\_\_\_\_  
Employer: \_\_\_\_\_ Pol. No.: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Gender:  Male  Female Phone: \_\_\_\_\_  
Marital Status: S M D W

Primary Care Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Past Medical History (please check the box and provide details in the space below)

- Ear problems
    - Dizziness
    - Decreased hearing
  - Eye problems
    - Failing vision
  - Sinus/Nose problems
  - Mouth or throat problems
  - Breathing disorders
    - Asthma/Wheezing
    - Shortness of breath
  - Heart & Circulation disorders
    - High Blood Pressure
    - Heart attack
    - Stroke
    - Anemia
    - Heart murmur
    - Clotting disorders
    - High cholesterol
  - Digestive disorders
    - Ulcers
    - Bloody stools
  - Liver disease
    - Jaundice
    - Cirrhosis
  - Kidney problems
  - Infectious disease
  - Other: \_\_\_\_\_
- Hepatitis A B, C, D
  - HIV/AIDS
  - Muscle, Joint or Bone problems
    - Back pain
    - Arthritis
    - Chronic fatigue
    - Osteoporosis
    - Multiple sclerosis
    - Paralysis
    - Fracture(s)
  - Mental health
    - Depression
    - Anxiety
  - Skin
    - Rashes
    - Easy bruising
  - Childhood illness
    - Chicken pox
    - Mumps
    - Polio
    - Rheumatic fever
  - Diabetes
  - Major injury
    - Auto accident
    - Concussion

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: (include the reaction you experience)  
\_\_\_\_\_  
\_\_\_\_\_

Social History:

Do you use alcohol? Y N If so, how many drinks per week on average? \_\_\_\_\_/week

Do you use tobacco (cigarette, cigar, chewing tobacco)? Y N If so, how much per day?  
\_\_\_\_\_/day

Do you use any 'street drugs'? Y N If so, what and how often? \_\_\_\_\_

Do you use caffeine (coffee, tea, soda pop)? Y N If so, how many cups per day? \_\_\_\_\_/day

Job description: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Recreational/Exercise activities: \_\_\_\_\_

Family History: (includes parents, grandparents, siblings, and own children)

- |                        |                       |                 |
|------------------------|-----------------------|-----------------|
| • Stroke               | • High blood pressure | • Cancer        |
| • Heart attack         | • Kidney disease      | • Foot problems |
| • Circulation disorder | • Osteoporosis        | • Other: _____  |
| • Diabetes             | • Arthritis           |                 |

Hospitalizations: (include hospital name, what for, and when)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries: (include procedure, where it was done, when and outcome)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications you are taking now (include all herbal and vitamin supplements)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_

Is there anything else your podiatrist should know about you and/or your health history?  
\_\_\_\_\_