Medical History

Date: _____

Name: _____ DOB: _____

Height: _____ Weight: _____ Shoe Size: _____ Dialysis Patient? Y/N

Employment Status: Y/N Retired (Please Circle)

Email: _____ Type of Work: _____

Primary Care Doctor: _____ Last Visit With Primary Doctor: _____

Please List Any Surgeries That You Have Had:

_____

_____

Medical Conditions: (Please Mark All That Apply)

___DIABETES	___HYPERTENSION	___RENAL FAILURE	___CANCER
___HEART DISEASE	___LIVER AILMENT	___SEISURES	___HIV/STD
___PREGNANT	___ANEMIA	___TUBERCULOSIS	___REFLUX/GI
___ARTHRITIS	___GOUT	___VASCULAR DISEASE	___STROKE
___HEPITITIS	___RHEUMATIC FEVER	___ASTHMA	___OTHER

Please List Any Medical Condition that is not Listed Above: _____

_____

Family History: (List Those Afflicted)

___DIABETES	___ASTHMA	___ANEMIA/ SICKLE CELL	___ARTHRITIS
___HEART DISEASE	___CANCER	___HYPERTENSION	___OTHER

Please List Current Medications:

_____

_____

_____

_____

_____

PATIENT'S SIGNATURE:

_____