Accnt #

PATIENT MEDICAL HISTORY

William Burleigh, D.P.M.

Patient Name:____Date:____________________

How were you referred to our office?____

1. Please describe the nature of your problem/illness:__________________________________

2. What activities or medications make the problem better or worse?______________________

3. Rate the severity of the problem from 1-10_______
4. Accident related?_____YES_____NO. IF YES, check one___employment___auto___Other
   A: Date of injury__________Time of injury__________
   B: How and where did accident occur?____
5. Have you ever had the same or similar symptoms_______yes_______no
6. Approximate date your symptoms began____
7. Have you ever had: ____rheumatic fever____tuberculosis____hepatitis____blood transfusion
8. List any surgical procedures you have had and the approximate dates____________________

9. Please circle any of the following conditions that you have been treated for within the last 5 years:

arthritis	cancer/tumors	kidney infections	asthma
diabetes	lung disease	angina	heart attack
stroke	back problems	heart failure	ulcers
blood clots	high blood pressure	weight problems	

10. List specific name of your current medications:____________________________________

11. List any allergies to medications:____

12. Do you smoke?______Yes______No How much per day?_______________
13. Do you drink alcohol beverages?______Yes______No How much?____________________
14. List any significant family history of medical problems______________________________

15. List ony other necessary medical information____________________________________

initials______________