FORT WORTH PODIATRY

Jon P. McCreary, D.P.M, FACFAS

Medical History

Name ______________________ Date of Birth ______________ Date ________

Gender: ___ Male ___ Female Height ______ Weight ______ Shoe Size ___________

Primary Care Physician ______________________ Referring Physician ______________________

Briefly, what problem(s) are you being seen for today? ______________________

Date of injury or start of symptoms ______________________

Allergies ______________________

Medical problem list: (Circle all that apply)

Anemia / Blood Disorder	Cancer	GERD / Acid Reflux	Liver Disease	Seizure Disorders
Arthritis	Congestive Heart Failure	Heart Disease / MI	Kidney Disease	Stroke
Asthma / COPD	Diabetes	High Cholesterol	Osteoporosis	Thyroid disorders
Depression / Anxiety	Gout	Hypertension	Peripheral Vascular Disease	Other _______________

Previous surgeries (add year performed, if known)

Medications you are currently taking

1	6
2	7
3	8
4	9
5	10

Pharmacy: ____

Address________________________________ Phone:________________________

Family History: Please list medical problems your parents/siblings have had such as diabetes, heart disease, cancer

Mother	Living / Deceased	______________________
Father	Living / Deceased	______________________
Brother	Living / Deceased	______________________
Sister	Living / Deceased	______________________

Do you smoke? Yes No If yes, how many packs per day? __________

Do you drink alcohol? Yes No If yes, how many drinks per week? __________

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.

FORT WORTH PODIATRY

Jon P. McCreary, D.P.M, FACFAS

REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

CONSTITUTIONAL		
Fever, chills	☐ Yes	☐ No
Recent weight gain or loss	☐ Yes	☐ No
EYES		
Vison changes	☐ Yes	☐ No
EARS, NOSE, THROAT		
Hearing loss	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
CARDIOVASCULAR		
Chest pain, fast heart rate	☐ Yes	☐ No
RESPIRATORY		
Chronic cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
GENITOURINARY		
Painful urination	☐ Yes	☐ No
Increased or decreased frequency	☐ Yes	☐ No
GASTROINTESTINAL		
Stomach upset, diarrhea, constipation	☐ Yes	☐ No
INTEGUMENTARY		
Skin rashes, lesions, or easy bruising	☐ Yes	☐ No
NEUROLOGICAL		
Pins and needles sensation in hands/feet	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
PSYCHIATRIC		
Depression, mood swings,	☐ Yes	☐ No
Sleep disturbance	☐ Yes	☐ No
MUSCULOSKELETAL		
Bone or Joint Pain	☐ Yes	☐ No
Swollen hands or feet	☐ Yes	☐ No
ALLERGIC/IMMUNOLOGIC		
Frequent sneezing, watery eyes	☐ Yes	☐ No

The above information is accurate to the best of my knowledge:

____________________________ ____________________

Patient's Signature Date

Please complete this form in its entirety at your first visit. It is the patient’s responsibility to notify our office of any changes to the information listed on this form.