**Brian Crispell D.P.M LLC**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY(DOCTOR/FRIEND)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SHOE SIZE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT( PLEASE SPECIFY IF JOB RELATED OR ACCIDENT):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PERSONAL MEDICAL HISTORY: (CIRCLE ALL THAT APPLY)**

**High Blood Pressure Heart Disease High Cholesterol Arthritis**

**Bleeding Problems Stomach Problems Nervous Problems/ Depression Stroke**

**Thyroid Disease Lung Problems Kidney Problems Gout**

**Cancer Hepatitis/Liver Problems Rheumatoid Arthritis HIV**

**Diabetes: Insulin \_\_\_\_\_\_\_\_\_\_\_\_\_ Pills \_\_\_\_\_\_\_\_\_\_\_\_\_ Other MEDICAL PROBLEMS: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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**RECENT SYMPTOMS (Circle all that apply) Weight change - Head injury - Headaches - Dizziness - Neck stiffness - Neck mass or lump - Shortness of breath - Cough - Coughing blood - Wheezing - Chest pain - Heart palpitations - Fainting - Dizziness upon Standing - Change in appetite - Problems eating - Belly pain - Change in bowel habits - Vomiting - Weakness - Tremors - Seizure - Pain in joints - Numbness - Problems walking**

**MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATION ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST-SURGICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SOCIAL HISTORY -SMOKING (Circle one) - YES NO FORMER NUMBER OF YEARS\_\_\_\_\_\_\_\_\_\_\_
FAMILY HISTORY: CIRCLE ALL THAT APPLY- (write in family member affected BELOW disorder)**

**Diabetes High Blood Pressure Heart Disease Cancer High Cholesterol**

**Bleeding Problems Thyroid Problems Stroke Gout Asthma/Lung Problems**

**PRIMARY DOCTOR NAME + ADDRESS + PHONE + LAST VISIT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**