Brian Crispell D.P.M LLC

NAME: _____ DATE OF BIRTH:_____REFERRED BY?_____

HEIGHT: _____ WEIGHT:_____ SHOE SIZE: _____

REASON FOR VISIT(PLEASE SPECIFY IF JOB RELATED) LEFT/RIGHT (Circle one or both)_____

_____

PERSONAL MEDICAL HISTORY: (CIRCLE ALL THAT APPLY)

High Blood Pressure	**Heart Disease**	**High Cholesterol**	**Arthritis**
Bleeding Problems	**Stomach Problems**	**Anxiety/ Depression**	**Stroke**
Thyroid Disease	**Lung Problems**	**Kidney dialysis OR disease**	**Gout**
Cancer	**Hepatitis/Liver Problems**	**Rheumatoid Arthritis**	**HIV**

Diabetes: Insulin _____ Pills _____ Other MEDICAL PROBLEMS: _____

_____

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: _____

_____

MEDICATION ALLERGIES: _____

PAST SURGICAL HISTORY: _____

_____

SMOKING (Circle one) /Never Smoker/ Former Smoker/ Light 1-9cigs a day/ Moderate 10-19 cigs a day/ Heavy More than 20 cigs a day ALCOHOL CONSUMPTION _____

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:

_____