

HEATHER N. McCOMBS, D.P.M.
PATIENT HEALTH HISTORY

NAME: _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

REASON FOR VISIT: _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

CURRENT MEDICAL HISTORY: _____

SURGICAL HISTORY: _____

SOCIAL HISTORY: TOBACCO:___ DRUGS:___ ALCOHOL:___ IF YES, HOW MUCH? _____

IMMUNIZATIONS: _____

FAMILY HISTORY: _____

PAST MEDICAL HISTORY: PLEASE INDICATE IF YOU'VE BEEN TREATED FOR ANY OF THE FOLLOWING. IF YES, PLEASE EXPLAIN BELOW.

- | | | |
|---|--|--|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> MENTAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> INDIGESTION/ULCER | <input type="checkbox"/> ALLERGIC REACTION |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> SKIN PROBLEM |
| <input type="checkbox"/> HEARING/EAR PROBLEM | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PODIATRY ISSUES |
| <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> LOW BACK PAIN | |
| <input type="checkbox"/> DENTAL PROBLEM | <input type="checkbox"/> FRACTURE/DISLOCATION | |
| <input type="checkbox"/> ALLERGIES/HAY FEVER | <input type="checkbox"/> CHRONIC FATIGUE | |
| <input type="checkbox"/> PNEUMONIA/BRONCHITIS | <input type="checkbox"/> WEIGHT LOSS (UNEXPLAINED) | |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANEMIA | |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> CANCER | |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DIABETES | |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> THYROID PROBLEM | |

EXPLANATION: _____

PATIENT SIGNATURE

DATE