PATIENT HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Shoe Size: _____

Activity Level (circle): Minimal Moderate High

Sports:

_____

_____

Medication(s): (Use back of page if more room needed)

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Illness: ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Kidney ☐ Lung ☐ PVD

☐ Arthritis ☐ Cancer ☐ Heartburn ☐ Headache ☐ Stroke

Allergies: _____

_____

Surgeries:

_____

_____

Any Family History of above Illnesses: _____

Social History : Smoker (circle): Yes / No **Drink Alcohol:** Yes / No

Today's Complaint:_____

_____