DEANNA LYNN INLOW, DPM

Patient: _____ **DOB:** _____

PAST MEDICAL HISTORY:

(*Please circle YES or NO to indicate if you currently have or have had any of the following medical problems)*

Anesthesia Complication	YES / NO	Gout	YES / NO	Osteoporosis	YES / NO
Anemia	YES / NO	HIV or AIDS	YES / NO	Pacemaker	YES / NO
Anxiety Disorder	YES / NO	Heart Attack (MI)	YES / NO	Peripheral Vascular Disease	YES / NO
Arthritis	YES / NO	Heart Disease	YES / NO	Pulmonary Embolism	YES / NO
Asthma	YES / NO	Heart Problems	YES / NO	Rheumatoid Arthritis	YES / NO
Bleeding Disorder	YES / NO	Hepatitis (Type: __)	YES / NO	Seizures/Epilepsy	YES / NO
Blood Clots	YES / NO	Hernia	YES / NO	Stroke	YES / NO
Cancer	YES / NO	Hypertension	YES / NO	Thyroid Problems	YES / NO
Coronary Artery Disease	YES / NO	Kidney Disease	YES / NO	Tuberculosis	YES / NO
Depression	YES / NO	Leg or Foot Ulcers	YES / NO	Ulcers	YES / NO
Diabetes (Type:_____)	YES / NO	Liver Disease	YES / NO	Urinary Tract Infection	YES / NO
GERD/Reflux	YES / NO	Lung Disease	YES / NO		

Other: _____

SOCIAL HISTORY *(Please select your answer)*

What is your exercise level? ❑ None	❑ Occasional	❑ Moderate	❑ Heavy
What is your level of alcohol consumption? ❑ None	❑ Occasional	❑ Moderate	❑ Heavy
What is your level of caffeine consumption? ❑ None	❑ Occasional	❑ Moderate	❑ Heavy
Do you use any illicit or recreational drugs? ❑ YES	❑ NO	If yes, which drug :	
Smoking status? ❑Never smoker ❑Former smoker ❑Current every day smoker ❑Current some day smoker			
Do you or have you ever used any other forms of tobacco or nicotine? ❑ YES	❑ NO		
Do you chew tobacco? ❑ YES ❑ NO		Do you use sunscreen routinely? ❑ YES ❑ NO	
Do you have an advanced directive? ❑ YES ❑ NO		Are you able to care for yourself? ❑ YES ❑ NO	

FAMILY HISTORY *(Please mark any known family history illnesses)*

Disease Name	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandmother	Maternal Grandfather
Diabetes								
Heart disease								
Heart attack								
Hypertension								
Cancer								
Arthritis								
Other:_____								
Other: _____								
Other:_____								
Other:_____								

Signature: _____ **Date:** _____

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