Chart #_____

BASIN PODIATRY, P.A.

Medical History Form

(Please use black ink)

Patient Name: _____ Date: _____
Who is your PMD? _____
When were you last seen? _____
(Need exact date for billing or insurance claim may be denied and is your responsibility for payment)
What Pharmacy do you use? _____
City and Phone number: _____

Medical History

Latex Allergy? O Yes O No
MedicalHistory_____
_____
_____
Allergies? _____
Previous surgeries? _____

Injury or current problem

What is your current problem?
_____
_____
_____

Are you having pain? O yes O no If yes, pain scale 1-10 (10 is worst pain possible) ___
What makes your symptoms worse? O Standing O Walking O Lifting O Exercise
O Lying in bed O Stairs O Resting, then standing and walking

Were you in E.R.? O yes O no Where? _____
Did you have imaging? _____
Is your injury work related? O yes O no If yes, employer? _____

Any surgeries for this problem? By whom?_____
Procedure 1 _____
Procedure 2 _____
Current work status? O regular O light duty O disabled O retired O student
O not working due to this problem O stay at home mom/dad
O nursing home _____
Where do you work? _____

Signature Patient or Legal Guardian _____
(All legal guardians with Power of Attorney please provide copy/DNR if applicable)