Dr. H. Kurtis Biggs, DO
Dr. Brian Wallace, DO
Dr. Jamie Weaver, DPM

Name: _____ **Date:** _____

Medical History Questionnaire

Please complete this medical history form to the best of your ability. If you need assistance, ask the assistant that brings you to the exam room for help. Please print clearly.

Allergies:

Medication	Reaction	Medication	Reaction

Medications:

Name	Dose	Frequency

Name	Dose	Frequency

If more space is needed, please continue list on back of page.

Herbal Supplements *Please list any herbal supplements you take*:

_____

Medical History & Review of Systems:

General Symptoms
□ Weight gain _____ lbs
□ Weight loss _____ lbs
□ Fever
□ Chills
□ Night sweats

Urinary Disorders
□ Incontinence
□ Prostate
□ Other:

Pulmonary Disease
□ Shortness of breath
□ Asthma
□ Emphysema
□ Other:

Cardiovascular System
□ High blood pressure
□ Heart attack
□ Chest pain
□ Arrhythmia
□ Circulation problems
□ High cholesterol
□ Heart murmur
□ Other:

Neuro/Psych
□ Stroke
□ Seizure
□ Depression
□ Anxiety
□ Other:

Skin
□ Psoriasis
□ Eczema

Ear, Nose, Throat
□ Hearing loss
□ Visual Problems
□ Headache

Musculoskeletal
□ Arthritis/Rheumatism
□ Gout
□ Osteoporosis
□ Fractures:
_____
_____
_____
_____

Gastrointestinal
□ Diarrhea
□ Constipation
□ Hepatitis **A B C** (*circle*)
□ Ulcers, reflux, GERD

Endocrine
□ Diabetes
□ Thyroid disease

Cancer
_____
_____
_____

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Past Surgical History

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If more space is needed, please continue list on back of page.

Family History:

	Father	Mother	Siblings
Deceased	□	□	□
Alcoholism	□	□	□
Asthma	□	□	□
Bleeding Disorder	□	□	□
Cancer	□	□	□
Diabetes	□	□	□
Heart Disease	□	□	□
Heart Failure	□	□	□
High Blood Pressure	□	□	□
Mental Illness	□	□	□
Osteoporosis	□	□	□
Stroke	□	□	□
Thyroid Disease	□	□	□
Other:			

Surgical Risks:

Latex Allergy	□ yes	□ no
Blood Transfusions	□ yes	□ no
Reaction: _____		
Reaction to Anesthesia:		
Personal	□ yes	□ no
Family	□ yes	□ no
History of Blood Clots		
Legs	□ yes	□ no
Lungs	□ yes	□ no

Social History:

Tobacco: Cigarettes _____ packs/day _____ years Alcohol: Type _____ amount/frequency _____

Recreational Drugs: □ yes □ no Type: _____

Living Situation: *(Please circle)* Home Other: _____ Family Alone

Occupation: _____ Employer: _____

Working: □ yes □ no If no, last date worked: _____

Education: (*Highest level completed*) _____

Sports/Hobbies: _____

By signing this form, I certify the information is accurate and correct to the best of my knowledge.

Signature: _____ Date: _____