William G. Gerlach, D.P.M.

Medical History Form

PLEASE PRINT LEGIBLY

Patient Name: _____ Date: _____

Past Medical History:

Hypertension (high blood pressure)	Y	N
Elevated Cholesterol	Y	N
Arthritis	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Cancer	Y	N

Other: _____

Past Surgical History: (please indicate each procedure and year performed)

_____

_____

_____

Medications:

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

Social History:

Do you smoke? Y / N Packs/Day _____

Do you have any history of alcoholism or substance abuse? Y / N

Marital Status (please circle): Single Married Divorced

Employment status: (please list/describe job if employed). _____

_____

Referred by: _____

Family History:

Hypertension	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent
Heart Disease	Mother	Father	Sibling	Grandparent

Other: _____

Review of Systems:

Do you wear corrective lenses? (glasses, contacts)		Y	N
Do you suffer from	Frequent headaches?	Y	N
	Dizziness?	Y	N
	Shortness of breath?	Y	N
	Episodes of chest pain?	Y	N
	Heartburn?	Y	N
	Numbness or tingling in extremities?	Y	N
	Back pain?	Y	N
	Chronic joint or muscle aches?	Y	N
Have you been diagnosed with liver or kidney disorders?		Y	N
Have you noticed changes in bowel or bladder habits?		Y	N
Have you had any recent significant changes in your weight?		Y	N

Patient Signature and Date_____

Physician Signature and Date_____