



Northeast Foot Care, PLLC
David Lambariski, DPM, FACFAS

Patient History

Reason for seeing doctor: _____

Medical History [Have you ever had any of the following?]

Diabetes	Hypertension	Arthritis
Cancer	Gout	Heart Attack
Irregular Heartbeat	Stroke	Bleeding Problems
Convulsions/Epilepsy	Asthma	Kidney Problems
Liver Problems	Thyroid Disease	Blood Clots
Stomach Problems	Nerve/Muscle Disorder	
Other: _____		

Review of Symptoms [Check symptoms you currently have or have had in the past year]

Genito-Urinary	Eye, Ear, Nose, Throat	General	Skin
Blood in urine	Bleeding gums	Chills	Bruise easily
Frequent urination	Difficulty swallowing	Dizziness	Hives
Lack of bladder control	Double vision	Fainting	Itching
Painful urination	Earache	Headache	Rash
	Ear discharge	Numbness	Sore that won't heal
Cardiovascular	Hay fever	Sweats	
Chest pain	Loss of hearing	Loss of sleep	Muscle/Joint/Bone
Rapid heart beat	Persistent cough	Loss of weight	Pain, weakness, numbness
Swelling of ankles	Sinus problems		in: _____

Allergies No Yes

Allergic to: _____ Specific reaction: _____

Allergic to: _____ Specific reaction: _____

Social History

Tobacco Use Never Previously but quit Current packs a day _____

Alcohol Use Never Social Moderate Daily

Are you pregnant? No Yes, due date is: _____

Surgical History [Please list previous surgeries]

1. _____

2. _____

3. _____

Medications [Please list your medications]

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Family Medical History

Mother: _____

Father: _____

Siblings: _____

Patient Signature: _____ **Date:** _____