

Name: _____ **Date:** _____

Associated Podiatry Group
Dr. Richard Primavera
Podiatric Physician and Surgeon

200 Norwood Ave.
Oakhurst, New Jersey 07755
(732) 695-6600

COMPREHENSIVE PATIENT MEDICAL HISTORY

Do you have or have you ever been treated for:

☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
☐ Phlebitis	☐ Vascular Disease	☐ A Heart Condition
☐ Anemia	☐ Poor Circulation	☐ Eyes:Glaucoma/Manicular Deg.
☐ Diabetes	☐ Kidney Disease	☐ Keloid/Thick Scar
☐ Gout	☐ Osteoporosis	☐ Alzheimer's
☐ Sciatica	☐ Lyme's Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Hearing/Ear Disorder
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Asthma	☐ Lung Disease	☐ Tuberculosis
☐ Hepatitis	☐ Liver Disease	☐ Thyroid Problem
☐ Dark Urine	☐ Chronic Light Stool	☐ Unexplained Weight Loss
☐ Cancer	☐ Stomach Ulcer	☐ ***NONE of these***

☐ Other(s): _____

List relationship to you of family members who have had:

Diabetes	_____	Foot Problems	_____
Arthritis	_____	Heart Attack	_____
Stroke	_____	High Blood Pressure	_____
Cancer	_____	Birth Defects	_____

# of childbirths ____ **Are you currently pregnant?** ☐ Yes ☐ No

Are you slow to heal after cuts? ☐ Yes ☐ No

Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No

Please mark if you take vitamins or supplements that contain ○ *garlic,* ○ *Gingko biloba,* ○ *echinacea,* ○ *ginseng or* ○ *St. John's Wort*

Are you currently taking any medications? List below! ☐ Yes ☐ No

Are you taking Insulin? If yes, list below. ☐ Yes ☐ No

When noting frequency: A = As needed, x/ = times per D = day, W = week,

List: Medications	Dose?	How Often?	For Treatment of?
		A x/ D W	
		A x/ D W	
		A x/ D W	
		A x/ D W	
		A x/ D W	

Are you taking your medications as prescribed? ☐ Yes ☐ No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:
(Check the answer box that applies)

	No	Yes	If yes, what happens?
Latex, Adhesive tape *(circle)*	☐	☐	
Penicillin	☐	☐	
Other antibiotics *(list below)*	☐	☐	
Empirin, Tylenol *(if yes, circle)*	☐	☐	
Aspirin, Advil, Aleve, or Motrin *(circle)*	☐	☐	
Celebrex	☐	☐	
Other pain remedies *(list below)*	☐	☐	
Morphine	☐	☐	
Codeine	☐	☐	
Demerol	☐	☐	
Other narcotics *(list below)*	☐	☐	
Novocaine	☐	☐	
Other anesthetics *(list below)*	☐	☐	
Sulfa drugs	☐	☐	
Shrimp, Iodine, or Merthiolate	☐	☐	
Any other drugs or medications	☐	☐	

Others: _____