Deanna Lynn Inlow, DPM

Patient: ______________________________ DOB: ____________________

PAST MEDICAL HISTORY (*Please indicate YES or NO on each item below.)*

Condition	Y/N
Anesthesia Complication	
Anemia	
Anxiety Disorder	
Arthritis	
Asthma	
Bleeding Disorder	
Blood Clots	
Cancer	
Coronary Artery Disease	
Depression	
Diabetes	
GERD/Reflux	

Condition	Y/N
Gout	
HIV or AIDS	
Heart Attack (MI)	
Heart Disease	
Heart Problems	
Hepatitis	
Hernia	
Hypertension	
Kidney Disease	
Leg or Foot Ulcers	
Liver Disease	
Lung Disease	

Condition	Y/N
Osteoporosis	
Pacemaker	
Peripheral Vascular Disease	
Pulmonary Embolism	
Rheumatoid Arthritis	
Seizures/Epilepsy	
Stroke	
Thyroid Problems	
Tuberculosis	
Ulcers	
Urinary Tract Infection	

SOCIAL HISTORY (*Please circle your answer)*

Occupation:				
Exercise level?	None	Occasional	Moderate	Heavy
Smoking status?	Never	Former	Current	Type:
Alcohol intake?	None	Occasional	Moderate	Heavy
Caffeine intake?	None	Occasional	Moderate	Heavy
Marijuana intake?	None	Occasional	Moderate	Heavy
Illicit Drug use?	YES	NO	If yes, which drug :	

Do you chew tobacco?	YES	NO	**Sunscreen used routinely?**	YES	NO
Advanced Directive?	YES	NO	**Are you able to care for self?**	YES	NO

FAMILY HISTORY (*Please list any known family history)*

1.
2.
3.

Signature: ____________________________________ **Date:** __________