MICHAEL J. KELLEY, D.P.M.
PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

Current Medications and strengths: _____

_____

Immunizations (Month/Year): Flu Shot _____, **Pneumonia Shot** _____

Medication Allergies: _____

_____

Past Surgical History: _____

_____

Are you pregnant?	**Yes**	**No**	
Are you HIV positive?	**Yes**	**No**	
Are you a Hepatitis Carrier?	**Yes**	**No**	
Are you a smoker?	**Yes**	**No**	**If yes, how much?** _____
Alcohol use?	**Yes**	**No**	**If yes, how much?** _____

I have/had:

( ) anemia	**( ) heart problems**	**( ) rheumatic fever**
( ) asthma	**( ) headache/dizziness/fainting**	**( ) rheumatism/arthritis**
( ) bleeding tendencies	**( ) high blood pressure**	**( ) shortness of breath/ wheezing/cough**
( ) cancer	**( ) kidney/bladder problems**	**( ) skin conditions**
( ) diabetes	**( ) knee/hip/lower back pain**	**( ) stomach ulcers**
( ) epilepsy	**( ) nervousness**	**( ) strokes**
( ) glaucoma/vision issues	**( ) paralysis/muscle weakness**	**( ) tuberculosis**
( ) gout	**( ) polio**	**( ) tumors**

Other: _____

Immediate Family Medical History:

( ) diabetes - Relationship _____
( ) cancer - Relationship _____
( ) heart problems – Relationship _____
( ) other _____

Shoe size: _____

Please state in your own words your medical reason(s) for coming to our office: _____

_____

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Doctor's Section: Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____

_____

_____

_____

_____