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**MEDICAL HISTORY FORM - PAGE 1**

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for seeing doctor today \_\_\_\_\_

Describe your pain (if applicable) \_\_\_\_\_ Length of pain \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

Activity level at work:  Sitting  Standing  Walking  Very active

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**Check all the medical conditions that you have now or have had in the past. If it does not apply, please leave blank.**

**Do you have:**  Fatigue  Chills  Nausea  Weight gain < 10 lbs  Weight loss > 10 lbs

**Vision:**  Impaired sight  Cataracts  Glaucoma  Infections  Macular degeneration

**Hearing:**  Hearing loss  Dizziness  Frequent ear infections  Loss of balance

**Nose:**  Sinus/allergies  Difficulty breathing  Deviated septum  Nose bleeds  Polyps

**Throat:**  Infections  Hoarseness  Speech difficulties  Swollen nodes/glands

**Respiratory:**  Asthma  Emphysema  Tuberculosis  Lung cancer  Collapsed lung  
 Bronchitis  Shortness of breath  Valley fever  Pneumonia

**Cardiovascular:**  High blood pressure  Pacemaker  Angina  Bypass surgery  Chest pain  
 Heart attack  Angioplasty  Palpitations  Rheumatic fever  Murmur/Valve Issue

**Vascular:**  Poor circulation  Blocked arteries  Blood clot  Leg pain at rest  
 High cholesterol  Varicose  Leg pain w/ walking  Phlebitis  Thrombosis

**Gastrointestinal:**  Reflux/heart burn  Abdominal pain  Liver disorder  Extreme hunger  
 Ulcer  Gallbladder  Colitis  Thirst  Hepatitis A / B / C  Appetite loss

**Genitourinary:**  Renal failure  Urinary tract infections  Dialysis  Stones  Frequent urination  
 Gonorrhea  Chlamydia  HIV  Syphilis  Herpes  
 Ovarian cancer  Prostate cancer

**Hematologic:**  Anemia  Leukemia  Sickle cell disease or trait  Blood transfusion

**Endocrine:**  Diabetes  Thyroid disorder

**MEDICAL HISTORY FORM - PAGE 2**

**Neurologic:**     Seizures     Stroke     Neuromuscular disease     Memory change     Numbness  
 Polio     Tremor     Sciatica     Frequent headaches     Muscle weakness

**Musculoskeletal:**    Any joint replacements or prosthesis? If yes, please give the date of surgery \_\_\_\_\_  
 Hip     Knee     Ankle     Hands     Feet     Spine

**Integument:**     Rashes     Psoriasis     Eczema     Color change to wart/mole     Skin cancer  
 Growths     Itching     Hives     Change in size of a skin growth

**Psychiatric:**     Depression     Anxiety     Memory loss     Difficulty concentrating     Suicidal  
 Nervousness     Phobias     Bipolar disease     Low self esteem

**Childhood:**     Measles     Mumps     Chicken pox     Herpes/cold sores

**Immunology:**     Weak immune system/frequent infections     Chronic fatigue syndrome/Epstein Barr

**Please list all major medical conditions of your biological family (if applicable):**

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Do you smoke?     No     Yes    \_\_\_\_\_ Pack(s)/Day    \_\_\_\_\_ Years  
Drink alcohol?     No     Yes    \_\_\_\_\_ Drink(s)/Day  
Other recreational drugs?     No     Yes    If yes, please specify: \_\_\_\_\_

**Women only - Are you pregnant?**     No     Yes    If yes, number of months along: \_\_\_\_\_

**Please list any other surgeries & date of procedure(s):** \_\_\_\_\_

**Any complications with surgery or anesthetics?**     No     Yes    If yes, please specify: \_\_\_\_\_

**List any hospitalizations, reason, and date:** \_\_\_\_\_

**Name all medications you are taking:** \_\_\_\_\_

**Are you allergic to any of the following? If yes, please state your reaction :** \_\_\_\_\_

Penicillin     Aspirin     Adhesive tape  
 Sulfa     Cortisone     Local anesthetics  
 Erythromycin     Codeine     Other \_\_\_\_\_