Dr. Rosemarie Caillier

Rosemarie Caillier, DPM, PC • 2002 McFarland Blvd E, Ste 207, Tuscaloosa, AL 35404 • Phone: 205-409-0175 • Fax: 205-764-5800

HEALTH HISTORY

Name _____ Date of Birth (MM/DD/YYYY) _____

Why are you seeing the doctor today? _____

_____

Weight: _____ Height: _____ Shoe Size: _____

Allergies: □ No Known Drug Allergies □ Adhesive / Tape
□ Codeine □ Iodine
□ Penicillin □ Sulfa
□ Latex □ Local Anesthetic
□ Other _____

Medications: (include herbal, vitamins, & supplements)

Name of Medication	Mg/Strength	Dose

Past Medical History

Surgeries / Hospitalization	Year

Are you currently having or have you had problems with:

Anemia	□ Yes □ No	Foot/Leg Cramps	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Arthritis	□ Yes □ No	Gout	□ Yes □ No	Scarring Tendency	□ Yes □ No
Artificial Valve or Joint	□ Yes □ No	Headaches	□ Yes □ No	Shortness of Breath	□ Yes □ No
Asthma	□ Yes □ No	Heart Disease	□ Yes □ No	Skin Problems	□ Yes □ No
Back Problems	□ Yes □ No	Hemophilia	□ Yes □ No	Stomach Problems	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Hepatitis	□ Yes □ No	Stroke	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Swelling in Ankle/Feet	□ Yes □ No
Chest Pain	□ Yes □ No	High Cholesterol	□ Yes □ No	Thyroid Problems	□ Yes □ No
Chills	□ Yes □ No	Joint Pain or Stiffness	□ Yes □ No	Tired Feet	□ Yes □ No
Circulatory Problems	□ Yes □ No	Kidney Problems	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes: □T1 □T2 __yrs	□ Yes □ No	Liver Disease	□ Yes □ No	Ulcers in foot or leg	□ Yes □ No
Ear problems	□ Yes □ No	Mental Disorder	□ Yes □ No	Varicose Veins	□ Yes □ No
Epilepsy	□ Yes □ No	Muscle Aches	□ Yes □ No	Weight Loss, unexplained	□ Yes □ No
Fever	□ Yes □ No	Radiation Treatment	□ Yes □ No	Other _____	

Social History

□ Employed □ Unemployed □ Disabled □ Student □ Retired Children: □ No □ Yes, how many _____

Do you use tobacco? □ No □ Yes Do you smoke cigarettes? □ No □ Yes: how much_____ how long _____

Previously a smoker? □ No □ Yes: quite for _____ years

Do you drink alcohol? □ No □ Yes: frequency _____ type _____ Drug Use □ No □ Yes type _____

Exercise: □ Daily □ Weekly □ Monthly □ Rarely □ Never If so, what type? _____

Family History: Has anyone in the family been diagnosed with the following disease? If yes, please indicate which family member

Cancer	□ Yes □ No	_____	Heart Disease	□ Yes □ No	_____
High Blood Pressure	□ Yes □ No	_____	Diabetes	□ Yes □ No	_____

Patient Signature: _____ Date: _____

FOR OFFICE STAFF

Reviewed by : _____ Date: _____