OLEAN MEDICAL GROUP LLP

PUNEET S. CHAHAL, D.P.M., FACFAS

Podiatric Medicine – Podiatric Surgery

535 Main Street, Olean NY Phone: (716) 376-2282 Fax: (716) 376-2281

Patient's Short Form History

Name: _____ **Age:** _____ **Date:** _____

Occupation: _____**Birth Date:** _____

Family MD: _____ **Date of last Physical:** _____

Chief Complaints: (Please list all symptoms)

1. _____ 3. _____

2. _____ 4. _____

Do you smoke? **Yes _____ No ____**
If yes, what do you smoke _____ How much _____
How many years: _____

Do you drink alcohol Yes _____ No _____
If Yes, what do you drink? Beer Wine Whiskey Other: _____
How much do you drink of each _____ Daily / Weekly / Monthly / Yearly (circle one)

Are you on a special diet? Yes _____ No _____
If yes, what kind of diet? _____

Allergies to medications Yes _____ No _____ (Please list all medications allergies)

_____

_____

Are you allergic to latex Yes _____ No _____
Are you allergic to foods, nail polish, or cosmetics? Yes or No **Other Allergies**: _____
What type of reaction do you have? _____

Medications

Are you taking any medications? Yes_____ No _____

If yes, please list:

Name	Dosage	Frequency (how often)

Operations/surgeries: Please list them all.

_____

_____

_____

List any serious illness:

_____

_____

Do you take antibiotics for dental visits? Yes _____ No _____

Do you have any of the following medication problems or issues? (Please circle)

Heart Lungs Liver Kidney Diabetes Circulation Blood Clots Phlebitis

When was your last EKG_____ Last Chest X-ray _____

WOMEN ONLY: Number of pregnancies _____ Number of children _____

Number of Miscarriages_____