Family Footcare, PC

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Patient History

Name:______________________________ Date of Birth: ____________ Age: _________

Vitals: Last Blood Pressure __________ Last Blood Sugar _______ Height _______ Weight______

Race: ☐ Asian ☐ American Indian ☐ Black(African American) ☐ Hispanic ☐ White

Other: ____

Drinking Status: ☐ None ☐ Social ☐ Moderate ☐ Heavy ☐ Former Drinker

Smoking Status: ☐ Never Smoked ☐ Smoke 1-5 times/day ☐ Smoke > 5/day ? PPD ________

☐ Former Smoker- How many years ago?________ How many packs/day? __________

Current Medications: ☐ I currently do not take any medications.

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

Name:____________________ Dose: ________________________

If you take more than 11 medications please list on a separate sheet.

Allergies: ☐ No known Allergies

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

Name:____________________ Reaction:________________________

If you have more than 9 allergies please list them on a separate sheet.

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Medical History: ☐ Alcoholism ☐ Blood Disorders ☐ Circulation problems ☐ Muscle pain
☐ Breathing issues ☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease
☐ Asthma ☐ Heart Murmur ☐ Stomach/Bowel issues ☐ Depression ☐ Anxiety Disorders
☐ Mental Illness ☐ Kidney Issues ☐ Blood Clots ☐ High Choesterol ☐ High Blood Pressure
☐ Cancer ☐ Hepatitis ☐ Neuropathy ☐ Thyroid Disease ☐ Diabetes ☐ Arthritis
☐ HIV ☐ Skin Disorders ☐ CVA ☐ Stroke

Please add description or any other medical condition not listed.

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Surgical History: ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts
☐ Joint Replacement ☐ Vascular Surgery Other Surgery: ____________________

____

Foot or Ankle surgery: ______________________________

____

Occupational history: ☐ Retired ☐ Unemployed presently I ☐ walk ☐ stand ☐ sit at work

Job Descrition: ______________________________

Excercise Level: ☐ I never excercise ☐ I excercise 1-3 times per week ☐ 4-7 times per week

Please describe your excercise routine. ____________________

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Family History: Is there and blood relation that suffers from the list below.? Please tell us what relation.

Alzheimers ______________ Arthritis ______________ Blood Clots ______________
Bleeding Disorders ______________ Cancer ______________ Cateracts ______________
Circulation Problem ______________ Depression ______________ Diabetes ______________
Emphysema ______________ Heart Disease ______________ Hypertension ______________
Neurologic ______________ Strokes ______________

Any other medical conditions run in your family? ______________________________

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Review of Systems: Circle if you have any of these symptoms or circle **"NONE"**

Cardiovascular	leg pain when walking, fever, chest pain/pressure, leg swelling, cold hands/feet, fainting, palpitations, vascular disease, valve problems	**NONE**
Genitourinary	blood in urine, hesitancy, incontinence, increased urgency, decreased frquency, excessive urination, kidney disease, kidney stones	**NONE**
Gastrointestinal	abdominal pain, heartburn, blood in stool, vomiting, ulcers, constipation, diarrhea, trouble swallowing, decreased appetite, increased appetite	**NONE**
Integumentary	athletes foot, nail abnormalities, keloids, itchiness, dry, scaly skin	**NONE**
Hematological	lower leg ulcers, sickle cell disease, anemia, blood thinners, clotting disorders	**NONE**
Neurological	tingling, weakness, seizures, numbness, headaches, tremors, paralysis	**NONE**
Musculoskeletal	back pain, joint swelling, muscle weakness, muscle pain, neck pain, sciatica, joint stiffness, joint pain, joint instablitiy, arthritis	**NONE**
Respiratory	chest pain, wheezing, COPD, coughing, snoring, shortness of breath, emphysema	**NONE**

The above information is correct to the best of my knowledge. I understand that throughtout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed on this form.

Patient Signature: ______________________ Date: ______________