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 Vaccinations: Influenza Pneumonia Hepatitis A Hepatitis B Shingles Tetanus

Current Medications: No medications. Other:

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
Please add description or any other medical condition not listed.

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 Description:
Excercise Level: ☐ I never excercise ☐ I excercise 1-3 times per week ☐ 4-7 times per week
Please describe your excercise routine

Falling History: ☐ I have not fallen in the past 12 months. ☐ I have fallen on the past 12 months.
☐ I have had loss of balance where I stumbled or tripped. ☐ I am unstable walking.

Family History: **Key GM=Grandparents P=Parents S=Brothers/Sisters C=Children O=Other family members**

	GM	P	S	C	O		GM	P	S	C	O		GM	P	S	C	O
Alzheimers	☐	☐	☐	☐	☐	**Arthritis**	☐	☐	☐	☐	☐	**Blood Clots**	☐	☐	☐	☐	☐
Bleeding Prob	☐	☐	☐	☐	☐	**Cancer**	☐	☐	☐	☐	☐	**Cataracts**	☐	☐	☐	☐	☐
Circulation Prob	☐	☐	☐	☐	☐	**Depression**	☐	☐	☐	☐	☐	**Diabetes**	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	**Heart disease**	☐	☐	☐	☐	☐	**Hypertension**	☐	☐	☐	☐	☐
Neurologic Prob	☐	☐	☐	☐	☐	**Stroke**	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

Any other medical conditions that run in your family?

Review of Systems: Check if you have any of these symptoms or check **"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: