Name: _____

What is your foot complaint/concern today? _____

_____

_____

Drug Allergies: □None or list_____

Medications: □None or list with Strength and Dosage

_____

_____

_____

Recent hospitalizations/ Prior surgeries: □None or list

_____

_____

Medical History: **Check all the boxes that apply or check none apply**

□ Asthma
□ Cancer
□ Diabetes
□ Fibromyalgia
□ Gout
□ Heart attack
□ Heart disease
□ Hepatitis
□ High blood pressure
□ Kidney disease
□ Multiple sclerosis
□ Osteoarthritis
□ Rheumatoid arthritis
□ Parkinson's
□ Stroke
□ Thyroid problems

None Apply

Review of Symptoms:

Constitutional
□ Fatigue
□ Fever
□ History of MRSA infection

Peripheral Vascular
□ Calf pain with walking
□ Cold feet
□ Previous bypass surgery in the legs
□ Varicose veins

Hematological/Lymphatic
□ Easy bruising
□ Past blood transfusion

Endocrine
□ Excessive sweating
□ Excessive thirst
□ Heat/cold intolerance

Musculoskeletal
□ Muscle pains/cramps
□ Joint stiffness
□ Backache

Integumentary
□ Moles or lesions
□ Skin rashes
□ Slow healing sores

Psychiatric
□ Anxiety
□ Depression
□ Memory loss

None Apply

Neurological
□ Fainting
□ Numbness, burning or tingling
□ Involuntary movements
□ Weakness
□ Seizures

Respiratory
□ Asthma

Have you fallen in the past 12 months?
NO: _____ YES: _____ If Yes - How many times**: _____** Were you injured?: _____

Social History: Alcoholic drinks per week: #_____ **Nicotine use**: □Never □Prior □Current- how much?_____

Physical activity level: □Inactive □Minimal □Moderate □Aggressive **Drug use/ abuse**: □Yes □No

Family History: Check and list relative (Immediate family members only i.e. Mom, Dad, Brother, Sister)

□Bleeding disorder_____ □Cancer_____ □Diabetes_____
□Drug abuse _____ □Heart disease_____ □High blood pressure_____
□Stroke_____ □Other: _____ □None

Patient signature: ***Date:***