ANKLE AND FOOT
– CARE –

MEDICAL HISTORY

PATIENT'S NAME _____ DATE _____

Please describe your foot problem: _____

Have you had any previous foot care or foot surgery?_____ If yes, by whom? _____

PHARMACY _____ Age: _____ Shoe Size: _____

Family Dr. _____ Height: _____ Weight: _____

GENERAL HEALTH

Please check any of the following which you or your immediate family have been or are being treated.

For Immediate Family, use: (M) Mother, **(F)** Father

Self	Immediate Family		Self	Immediate Family	
____	_____	A-Fib	____	_____	Hearing Loss
____	_____	Acid Reflux GERD, Stomach Ulcer	____	_____	Heart Attack / Stroke
____	_____	ADHD	____	_____	High Cholesterol
____	_____	Anxiety	____	_____	Hypertension (High Blood Pressure)
____	_____	Arthritis (Type)	____	_____	Knee / Hip Problems
____	_____	Asthma	____	_____	Liver Disease (Hepatitis)
____	_____	Autism	____	_____	Lupus
____	_____	Back Problems (Sciatica / Spinal Stenosis, DJD)	____	_____	Mitral Valve Prolapse (Heart Murmur)
____	_____	Bleeding Disorder	____	_____	Parkinsons
____	_____	Cancer **Type:** _____	____	_____	Peripheral Vascular Disease (Circulation), Raynauds
____	_____	Cardiac Disease (Heart Disease)	____	_____	Phlebitis / Thrombophlebitis
____	_____	Cataracts, Macular Degeneration	____	_____	Polio, Cerebral Palsy, Muscular Dystrophy, MS
____	_____	Congestive Heart Failure	____	_____	Prostate Problems
____	_____	COPD	____	_____	Psoriasis / Skin Problems
____	_____	Dementia / Alzheimer's	____	_____	Renal Disease (Kidney)
____	_____	Depression	____	_____	Restless Legs
____	_____	Developmental Delay	____	_____	Seizure Disorder / Epilepsy
____	_____	Diabetes - (Type 1, Type 2)	____	_____	Thyroid (Hypo or Hyper)
____	_____	Diverticulitis	____	_____	Venereal Disease / AIDS / HIV+
____	_____	Fibromyalgia	____	_____	Vertigo / Balance Problems
____	_____	Glaucoma / Eye	____	_____	**Other:** _____
____	_____	Gout			
____	_____	Headaches / Migraines			

Women, are you pregnant? _____ LMP _____ Due Date _____

ALLERGIES _____ No Known Drug Allergies

Are you allergic to any of the below? Please check and list reaction

____ Adhesive Tape _____	____ Environmental _____	____ Pain Medication _____
____ Aspirin _____	____ Foods _____	____ Penicillin _____
____ Caffeine _____	____ Iodine / Betadine _____	____ Sulfa Drugs _____
____ Cipro _____	____ IV Contrast Dye _____	____ Tetracycline _____
____ Codeine _____	____ Latex _____	____ **Other** _____
____ Cortisone _____	____ Novocaine _____	

Continue on back side →

PERSONAL SOCIAL HISTORY

Marital Status: _____

Who do you live with: _____

How many children: _____

Are you employed?: _____

Occupation (current or former): _____

Are you a smoker?: _____

How much do you smoke per day?: _____

Do you drink caffeinated beverages (cola, coffee, or tea)?: _____

Number of beverages per day: _____

Do you drink Alcohol?: _____

Number of beverages per day: _____

Are you taking any medications? Yes_____ **No**_____ If yes, please list:

Please list all medications including Vitamins, Birth Control Pills, Herbs and any over the counter medications. Please include milligrams and how you take the medication.

	Medication	Milligrams	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you had any previous surgery or hospitalization?

Yes_____ **No**_____ Please list:_____

CONSENT FOR TREATMENT

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary by Ankle & Foot Care.

Date:_____

X_____ _____

Signature of patient or consenter Witness

CONSENT OF PHOTOGRAPHY

I hereby authorize Ankle & Foot Care to take medical photographs which are to be used solely for the purpose of education.

X_____ Date_____

Signature