Family Foot Center

PATIENTS MEDICAL HISTORY

Patient Name _____
Last First Middle Initial

Birthdate _____ Height _____ Weight _____lbs

Foot Complaint: _____ □Right □ Left □ Both

Past/Present Medical History

Have you had any of the following: (Check all that apply) **□None**

Heart
□ Heart Attack (MI)/Angina Date_____
□ Coronary Bypass/Stent Date_____
□ Pacemaker Type_____
□ Coronary Artery Disease
□ Congestive Heart Failure
□ Mitral Valve Prolapse
□ High/Low Blood Pressure
□ Heart Murmur
□ Arrhythmia (A Fib)
On blood thinners □Yes □No
□ Blood Clots/DVT/Pulmonary
□ Anemia/Bleeding Disorder

Lung
□ COPD
□Asthma
□Emphysema
□ Breathing Problems
□ On Supplemental Oxygen
□ Sleep Apnea/C Pap/Other

Neurological
□ Stroke/TIA Date_____
□ Epilepsy/Seizures/Convulsions
□Fibromyalgia
□ Numbness or tingling lower leg
□ Weakness
□Restless Legs Syndrome

Eye
□ Glaucoma/Retinal Detachment

Endocrine
□ Diabetes, Type I/Type II
□ Peripheral Neuropathy
□ Peripheral Vascular Disease
□ Kidney Disease/ESRD/Dialysis
□ Liver Disease
□ Thyroid Disease Hypo/Hyper
□ Chemotherapy/Radiation Therapy
□ Cancer Type: _____
□ Autoimmune Disease or Syndrome
Type: _____

Musculoskeletal
□ Joint Replacement Back/Hip/Knee/Shoulder/Feet
□ Muscular Dystrophy
□ Osteoporosis/Osteopenia
□ Arthritis
□ Chronic Pain Syndrome

Lower Extremity
□ Foot Ulcers/Wounds
□ Legs Swollen/Edema
□ Varicose Veins
□ Gout

Psychological
□ Anxiety/Depression

Infectious Disease
□ Tuberculosis Date_____
□ MRSA/C-Diff/COVID+ Date_____
□ Hep A/B/C Date _____

Other Information if not mentioned above:
_____
_____
_____
_____

Complete both sides

Social History

Occupation _____ Industry _____

Marital Status _____ Children _____

Do you use tobacco? □None If Yes Years of Use _____ Packs Per Day: _____ If Quit/When: _____

Do you drink alcohol? □None If Yes □ Social □ Moderate □Heavy

Current or history of substance use (including marijuana products) □No □Yes

Type: _____How Much/ Often: _____

Can you climb a flight of stairs without becoming short of breath, dizzy, lightheaded or chest pain? □No □Yes

Medications (Please list ALL medications including prescriptions, over the counter, blood thinners)

Medication	Dose	How Often

□ I have brought a list to photocopy □ I take No medications

Allergies (Please list ALL allergies including contrast dyes, metal, latex, adhesive tapes, medications or other)

Allergies ☐ I have no known drug allergies	Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)

Previous Surgeries (Please list ALL previous surgeries Heart, Lung, Joints, Cancer etc. and Date) ☐ None

Surgery	Date

The above information is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Complete both sides