

When your feet need a specialist...



Family Foot Care

MEDICAL INFORMATION SHEET

Patient Name

Today's Date

PLEASE CHECK THE MEDICAL PROBLEMS YOU HAVE:

- | | |
|-------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy, Seizure |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke (date: _____) |
| <input type="checkbox"/> Heart Attack (Date of last attack _____) | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease (Hepatitis/Cirrhosis) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach Problems (Ulcers/Gastritis/Hiatal Hernia) |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia/Prolonged Bleeding |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Cancer (type: _____) |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Unusual Childhood Diseases | <input type="checkbox"/> Tuberculosis |

Other Illnesses _____

FAMILY HISTORY: (Please write on line below any medical problems that run in the family.)

MEDICATIONS & DOSAGES (Please list):

ALLERGIES (please circle or list) Penicillin Demerol Codeine Tape Iodine Sulfa

PAST SURGERIES & HOSPITALIZATIONS

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

SOCIAL HISTORY:

Smoke/chew tobacco: ___no ___yes How much? ___packs/day x ___years - Alcohol Use: ___no ___yes

JOB/EXERCISE REQUIREMENTS:

DESCRIBE YOUR FOOT/ANKLE PROBLEMS: _____

Family Foot Care Staff

Doctor Signature