InStride Family Foot Care

PATIENT NAME_____

DATE OF BIRTH_____

MEDICAL INFORMATION SHEET

Do you have or have you been treated for:

☐ Diabetes	☐ Poor Circulation	☐ Gout
☐ High Blood Pressure	☐ Phlebitis	☐ Liver Disease (Hepatitis/Cirrhosis)
☐ Heart Disease	☐ Vascular Disease	☐ Stomach Problems
☐ Heart Attack	☐ Epilepsy, Seizure	(Ulcers/Gastritis/Hiatal Hernia)
☐ Kidney Disease	☐ Nervous Disorders	☐ Anemia/Prolonged Bleeding
☐ Arthritis	☐ Stroke	☐ Cancer
☐ Lung Disease	☐ Thyroid Disease	☐ HIV/AIDS
☐ Other _____		☐ Tuberculosis

Are you currently taking any medications: ☐ Yes ☐ No If yes, list below.

_____

_____

_____

Allergies:_____

Pharmacy Name:_____

Do you give us permission to pull your medicine history?_____

List any sugeries you have had: _____

_____

Family History: ☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐Other_____

Do you smoke: ☐ Y ☐ N **Packs/day/years**_____

Please describe the reason for your visit today: _____

_____

Please check the positives on the list below if you have any of the following symptoms:

CONSTITUTIONAL: ☐ Fever ☐ Chills ☐ Fatigue ☐ Night Sweats ☐ Recent Weight Loss

CARDIOVASCULAR: ☐ Cough ☐ Chest Pain ☐ Difficulty Breathing ☐ Leg Swelling

SKIN: ☐ Rash ☐ Excess Dryness ☐ Itching ☐ Hives ☐ Toenail Ingrown

MUSCULOSKELETAL: ☐Back Pain ☐Leg Pain ☐Hand Pain ☐Joint Pain ☐Stiffness or Swelling ☐Foot Pain ☐Ankle Pain

EAR, NOSE, AND THROAT: ☐ Sore Throat ☐ Hoarseness ☐ Congestion ☐ Bleeding

GASTROINTESTINAL: ☐ Stomach Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Black or Bloody Stools

GENITAL/URINARY SYSTEM: ☐ Frequency ☐ Burning with Urination ☐ Pain with Urination

NEUROLOGICAL SYSTEM: ☐Headache ☐Blackouts ☐Loss of Feeling or Power ☐Difficulty Speaking ☐Numbness Tingling

VISION: ☐ Blurred Vision ☐ Double Vision ☐ Dry Eyes

Other Symptoms You Are Experiencing: _____