FOOT CARE CENTERS

PATIENT MEDICAL INFORMATION

PATIENT NAME:____

REASON FOR TODAY'S VISIT:
____

____

ALLERGIES TO MEDICATIONS (PLEASE CIRCLE REACTION TO DRUG):

Drug______________________________	Rash	Stomach Upset	Hives
Drug______________________________	Rash	Stomach Upset	Hives
Drug______________________________	Rash	Stomach Upset	Hives
Drug______________________________	Rash	Stomach Upset	Hives
Drug______________________________	Rash	Stomach Upset	Hives

LIST MEDICATIONS ALONG WITH DOSE AND FREQUENCY:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS: (PLEASE CHECK ALL THAT APPLY)

____ Artificial Joints	____Asthma	____ Bleeding Disorder
____ Depression	____ GI/Stomach Problems	____ Diabetes (insulin/non-insulin)
____ Heart Disease	____ Hypertension	____ Hepatitis A B C(please circle)
____ Kidney Disorder	____ Blood Clots	____ Lupus / Autoimmune Disease
____ Seizures/Epilepsy	____ Thyroid Disease	____ Irreg.Heart Beat/Heart Murmur
____ Osteo Arthritis	____ Rheumatoid Arthritis	____ Shortness of Breath
____ Emphysema	____ COPD	____ Stomach/Intestinal Disorder
____ Swollen Legs	____ PVD	____ Tuberculosis

SURGERIES/HOSPITALIZATIONS (PLEASE LIST WITH EACH DATE):

____ ____
____ ____
____ ____

FAMILY MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY

_____Autoimmune Disease ____Cancer ____Heart Disease ____Diabetes ____Hypertension ____Arthritis

DO YOU USE TOBACCO PRODUCTS? (PLEASE CIRCLE) Yes No #Packs _____ #Years_____

DO YOU DRINK ALCOHOL? (PLEASE CIRCLE) Yes No #Drinks/week ____________________