Complete Family Foot Care- Physical History Form

Name: ____

What is your foot complaint/concern today? ____

____

____

Drug Allergies: ☐None or list____

Medications: ☐None or list with Strength and Dosage

____

____

____

Recent hospitalizations/ Prior surgeries: ☐None or list

____

____

Medical History: **Check all the boxes that apply or check none apply**

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Fibromyalgia
☐ Gout

☐ Heart attack
☐ Heart disease
☐ Hepatitis
☐ High blood pressure
☐ Kidney disease

☐ Multiple sclerosis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Parkinson's
☐ Stroke
☐ Thyroid problems

☐ **None Apply**

Review of Symptoms:

Constitutional
☐ Fatigue
☐ Fever
☐ History of MRSA infection

Peripheral Vascular
☐ Calf pain with walking
☐ Cold feet
☐ Previous bypass surgery in the legs
☐ Varicose veins

Hematological/Lymphatic
☐ Easy bruising
☐ Past blood transfusion

Endocrine
☐ Excessive sweating
☐ Excessive thirst
☐ Heat/cold intolerance

Musculoskeletal
☐ Muscle pains/cramps
☐ Joint stiffness
☐ Backache

Integumentary
☐ Moles or lesions
☐ Skin rashes
☐ Slow healing sores

Psychiatric
☐ Anxiety
☐ Depression
☐ Memory loss

☐ **None Apply**

Neurological
☐ Fainting
☐ Numbness, burning or tingling
☐ Involuntary movements
☐ Weakness
☐ Seizures

Respiratory
☐ Asthma

Have you fallen in the past 12 months?
NO: _______ **YES:** _________ **If Yes -** How many times**:** ________________ Were you injured?: ________________________

Social History: Alcoholic drinks per week: #______ **Nicotine use**: ☐Never ☐Prior ☐Current- how much?_______________

Physical activity level: ☐Inactive ☐Minimal ☐Moderate ☐Aggressive **Drug use/ abuse**: ☐Yes ☐No

Family History: Check and list relative (Immediate family members only i.e. Mom, Dad, Brother, Sister)

☐Bleeding disorder____________________ ☐Cancer____________________ ☐Diabetes______________________________
☐Drug abuse ________________________ ☐Heart disease_______________ ☐High blood pressure____________________
☐Stroke____________________________ ☐Other: ___________________ ☐None

Patient signature: ________________________ ***Date:*** ____________