TOTAL FOOT CARE

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PATIENT'S MEDICAL INFORMATION

Patient's Name: ____

Primary Physician's Name: ______________________________Date of last exam: ____________

Physician's Address: ___________________________ Reason for last treatment: ____________

___________________________ ______________________________

Physician's Phone: ___________________________ **Health**: Good ☐ Fair ☐ Poor ☐

Medications: dosage and how often you take them: ___________________________________

____ None ☐

Operations/Serious Illness: Yes ☐ No Please give details: ______________________________

____

Have you ever been treated for substance **abuse**? Alcohol ☐ Drugs ☐ None ☐

Do you **drink**? Yes☐ No☐ How much? __________ Do you **smoke**? Yes☐ No☐ How much?__________

Have you experienced any unusual or allergic **reactions** to: Penicillin ☐ Aspirin ☐ Sulfa ☐

Codeine ☐ Novocain/Xylocaine ☐ Iodine ☐ Tape ☐ Foods ☐ None ☐

Other ☐ ____

Please **CIRCLE** if you have ever had or now have:

Diabetes-- Cancer-- Thyroid Problems-- Respiratory Problems/Asthma-- HIV positive/AIDS--

High Blood Pressure-- Heart Problems-- Hepatitis-- Tuberculosis-- Epilepsy--

Gout-- Arthritis-- High Cholesterol-- Venereal Disease/STD-- Difficulty in Healing--

Acid Reflux-- Stomach Ulcer-- Phlebitis-- Blood Clots-- Bad Circulation--

Skin Problems-- Nervous Condition-- Depression-- Numbness to Feet or Legs--

What is you current foot/ankle **problem**?

____

I certify that the above information is true to the best of my knowledge. I further understand that it will not be given out and it is confidential. I agree to allow the doctor to examine me and understand treatments will be explained to me before they are started.

Patient's Signature: ____ **Date**: ____________