Foot Care Solutions Patient Medical Questionnaire

Patient Name: ________________________________ DOB: ____________

What is the primary complaint for which you are seeking treatment today?
____
____

Past Medical History: Please check any present or past medical problems listed below.

Diabetes	____	Heart Disease	____	Lung Disease	____
Poor Circulation	____	Kidney Disease	____	Depression/Anxiety	____
Neuropathy	____	High Cholesterol	____	Gout	____
Multiple Sclerosis	____	Liver Disease	____	Ulcers	____
Bleeding Disorder	____	Thyroid Problems	____	AIDS/HIV	____
High Blood Pressure	____	Cancer	____	Tuberculosis	____
Stroke	____	Arthritis	____	Blood Clots	____

Any other medical problems? ____
____
____

Surgical History: Please list procedures and dates.
____
____
____

Medications:
____
____
____
____
____
____
____
____
____

Allergies: Please list allergy and reaction.
____
____

Social History:
Tobacco: Yes ____ No ____ Alcohol: Yes ____ No ____ Substance Abuse: Yes ____ No ____

By signing below, I attest that the information above is complete, accurate, and answered to the best of my knowledge.

Patient/Responsible Party Signature: ______________________________ Date: ____________