

Name \_\_\_\_\_ Sex \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Cell# \_\_\_\_\_ Email \_\_\_\_\_

Family Dr. \_\_\_\_\_ Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size \_\_\_\_\_

Allergies \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How many years? \_\_\_\_\_

Check the following medical conditions that apply: ☐ heart disease ☐ stroke ☐ respiratory

☐ cancer ☐ osteoporosis ☐ arthritis Others: \_\_\_\_\_

Check if you are taking any of the following medications: ☐ anti coagulants (blood thinners) ☐ steroids

☐ non-steroidal anti-inflammatories ☐ antibiotics ☐ diuretics (water pill)

List any surgeries \_\_\_\_\_

Health history pertinent to foot care \_\_\_\_\_

Today's foot concerns \_\_\_\_\_

Previous foot care experience \_\_\_\_\_

Who has been caring for your feet? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ May we thank someone for the referral? \_\_\_\_\_

Any history of falls? (explain) \_\_\_\_\_

Check any mobility aids used: ☐ cane ☐ walker ☐ wheelchair. Other: \_\_\_\_\_

Are you a diabetic? \_\_\_\_\_ (if NO please proceed to line marked with\*) How many years? \_\_\_\_\_

Are you on Insulin? \_\_\_\_\_ List type \_\_\_\_\_

Do you take oral medication? \_\_\_\_\_ List type \_\_\_\_\_

How often do you check your blood sugar? \_\_\_\_\_ BS range \_\_\_\_\_

How often do you check your Hemoglobin A1C? \_\_\_\_\_ Last result \_\_\_\_\_

\*Any history of leg ulcers? (explain) \_\_\_\_\_

Any issues with your circulation? (i.e. PVD) \_\_\_\_\_

Any loss or altered sensation? (numbness, tingling, burning, pins and needles) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_