

## Foot Care of Clifton Park Medical History Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

What is your foot complaint today? \_\_\_\_\_

How long has this problem existed? \_\_\_\_\_

What is your level of pain? (0 no pain, 10 extreme pain) \_\_\_\_\_

Have you ever been treated for this before? \_\_\_ yes \_\_\_ no

If yes, please provide the name of the provider and the treatment that was done \_\_\_\_\_.

Do you have or have you ever had ANY of the following conditions:

Diabetes	Y N	Bleeding Tendencies	Y N
High Blood Pressure	Y N	Pulmonary (Lung) Disease	Y N
Heart Disease	Y N	Gastrointestinal Disease	Y N
Arthritis	Y N	High Cholesterol	Y N
Asthma	Y N	Frostbite	Y N
Anemia	Y N	Other	

List any medications you are currently taking:

Do you have any allergies to medication? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If Yes, How Much? \_\_\_\_\_

List any previous surgeries: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

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