

Foot Care of Clifton Park Medical History Information

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:
Circle Y (Yes) or N (No)

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?_____

List any previous surgeries:_____

Signature _____ Date _____