Foot Care of Clifton Park
Medical History Information

Name: _____ **Age:** _____ **Shoe Size:** _____

Height: _____ **Weight:** _____

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**	**Anemia**	**Y N**
Other			

******please document any medical history not elsewhere specified******

List any medications (please include dosage) you are currently taking:

_____

_____

List any allergies you have to medication: _____

Do you smoke? _____ **If Yes, How Much?** _____

List any previous surgeries: _____

_____

Pharmacy Name: _____ **Location:** _____

Signature _____ **Date** _____

* Like Foot Care of Clifton Park on Facebook