Family Footcare, PC Patient History

Date:		Name:		Height:		Weight:	

Chief Complaint: (What is bothering you?)	
What are your symptoms? (Where, when and how bad does it bother you?)	
Home Treatments: (What have you tried at home and did it help?)	
Previous Professional Treatment: (Who have you seen and what was done?)	

Please check any Foot or Ankle Problems you have ever had:

☐ Achilles Issues	☐ Ankle Pain	☐ Arthritis	☐ Athlete's Feet	☐ Bleeding	☐ Bruising	☐ Bunions
☐ Burning Pain	☐ Cold Feet	☐ Corns/Calluses	☐ Foot Cramps	☐ Foot Ulcers	☐ Forefoot Pain	☐ High Arches
☐ Heel Pain	☐ Ingrown Nails	☐ Numbness	☐ Odor	☐ Swelling	☐ Thick Toe Nails	☐ Warts

Other:

Please use the drop down boxes to tell us if you, your immediate family or both have any of the following conditions.

AISD/HIV		Bleeding Problems		Epilepsy		Kidney Problems		Sinus Problems	
Anemia		Blood Clots		Eye Probroblems		Liver Problems		Stroke	
Angina		Cancer		Fainting		Neuropathy		Swelling Feet/Ankles	
Arthritis		Chest Pain		Foot/Leg Cramps		Phlebitis		Thyroid Problems	
Artificial Heart Valves		Cholesterol Problems		Gout		Rashes		Tuberculosis	
Artificial Joints		Circulation Problems		Headaches		Lung Problems		Foot Ulcers	
Asthma		Diabetes		Heart Disease		Sickle Trait/Anemia		Stomach Ulcers	
Back Problems		Ear Problems		Hemophilia		Hypertension		Varicose Veins	

Other:

Please list your current medication on our medication form on our web site or bring in a list of your medications.

Previous Surgeries:

Caffeine/Day		Alcohol Intake		Tobacco/Day		Pregnancy	

Physician Name and Address:		Date of Last Visit:	