Carolina Foot Care, LLC
Medical History Form

Name:_____ Date:_____

Family Physician:_____ Date last seen:_____

How did you hear about our office? _____

Please describe reason for visit:_____

Age_____ Height _____ Weight _____ Shoe Size _____

Are you currently taking any medication? ☐ Yes (If yes, please complete Universal Medication Form) ☐ No

Do you have allergies to any medications? ☐ Yes (If yes, please complete Universal Medication Form) ☐ No

Please tell us if you have ever had any of the following conditions:

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Liver Disease: ☐ Hepatitis ☐ Jaundice ☐ Cirrhosis
☐	☐	Abnormal Blood Pressure: ☐ High ☐ Low	☐	☐	Neuromuscular: ☐ Polio ☐ CP ☐ MS
☐	☐	Arthritis: ☐ Rheumatoid ☐ Osteo	☐	☐	Parkinson's
☐	☐	Asthma	☐	☐	Pneumonia
☐	☐	Blood clot/Phlebitis	☐	☐	Poor Circulation
☐	☐	Blood Disorders: ☐ Anemia ☐ Sickle Cell	☐	☐	Psychiatric Care
☐	☐	Cancer	☐	☐	Rheumatic Fever
☐	☐	Congenital Heart Disease	☐	☐	Seizures/Epilepsy
☐	☐	COPD	☐	☐	Stomach Ulcers
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Gout	☐	☐	Thyroid: ☐ Hypo ☐ Hyper
☐	☐	Heart Disease/Heart Attack	☐	☐	Thick Scar/Keloid
☐	☐	HIV/AIDS	☐	☐	Tuberculosis
☐	☐	Intestinal Disorders	☐	☐	Venereal Disease
☐	☐	Kidney Disease: ☐ Kidney Stones ☐ Renal Failure			

Other: _____

List and give year of all hospitalizations/surgeries:_____

_____

Continue to back

Social History (Please tell us if you have any past or present use)

Tobacco: ☐ Yes ☐ No Number of years _____ Packs per day _____ Date quit (if applicable) _____

Alcohol: ☐ Yes ☐ No Drinks per day _____

Social Drugs: ☐ Yes ☐ No Please list _____

Tetanus Immunization: ☐ Yes ☐ No Date of last booster: _____

Activity Level: ☐ low ☐ moderate ☐ high Occupation: _____

Pneumonia Vaccination: ☐ Yes ☐ No Date of vaccination: _____

Flu Immunization: ☐ Yes ☐ No Date of last immunization: _____

Family History (Please tell us if any immediate family members have a history of the following):

	High Blood Pressure	Diabetes	Heart Disease	Cancer	Blood Disorders	Foot Problems
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐
Aunt	☐	☐	☐	☐	☐	☐
Uncle	☐	☐	☐	☐	☐	☐

Review of Systems (Please tell us whether you have recently experienced any of the following problems):

Yes	*No*		*Yes*	*No*	
☐	☐	Bruising	☐	☐	Lower Back Pain
☐	☐	Change of bowel habits	☐	☐	Nasal Discharge
☐	☐	Change in Weight	☐	☐	Nausea and/or Vomiting
☐	☐	Chest Pain	☐	☐	Night Sweats
☐	☐	Cough	☐	☐	Nose Bleeds
☐	☐	Dizziness	☐	☐	Ringing in Ears
☐	☐	Discolored Urine	☐	☐	Shortness of Breath
☐	☐	Feeling Anxious or Hopeless	☐	☐	Skin Rash/Lesions
☐	☐	Frequent Headaches	☐	☐	Tingling/Burning in Extremities
☐	☐	Heart Murmur/Palpitations	☐	☐	Urinary Frequency
☐	☐	Heartburn or Indigestion	☐	☐	Weakness/Lethargic
☐	☐	Joint Deformities	☐	☐	Wear Glasses or Contacts
☐	☐	Joint Pain/Swelling			