

## Anderson Foot Care Patient Medical History

Name	Age	DOB
Main Reason for today's visit:		
Name of Your Primary Care Physician:		Date of Last Visit:
Family History of diabetes and/or foot problems? If so please provide details:		
Percentage of time on your feet?	Occupation:	
Sports or physical activities?		
Have you had back, hip, knee, ankle or foot surgery?		
Please list all prescriptions / over the counter medications and vitamins you take:		None
Please list all Allergies:		None
History (Please check if Yes)		
Cramping in Legs	Numbness or Burning	
Pain in calves or buttocks when walking	Does rest relieve pain	
History of foot or leg ulcers	History of falling / recent falls	
Feet hurt at night	Difficulty walking / use of cane / walker	
Do you have vascular grafts	Do you have replacement heart valve	
Females: Pregnant    Nursing    LMP:	Weight Gain	
Alcohol Use                    Quantity	Tobacco Use	Frequency
Hospitalizations?		
Has anything changed with your health since your last visit?		
Do you have any of the following? (Please check if Yes)		
Abnormal bleeding / Hemophilia	Recent fever, fatigue or weight loss	
Bleeding problems, bleed easily	Rheumatologic disease, arthritis, lupus	
Cancer                    If yes, what type	Sinus or lung disease (asthma, emphysema/COPD)	
Diabetes, thyroid or other hormone disease	Skin allergies	
Difficulty breathing / shortness of breath	Slow or rapid heart rate	
Drying peeling, itching, flaking or burning skin	Specific skin disease (type)	
Fainting spells / seizures	Stomach or intestinal problems with medications	
Frequent infections	Sore throat, sinus or nosebleeds	
Grittiness or burning of the eyes	Stroke, severe headaches, nerve problems	
Heart attack	Visual Problems	
High blood pressure	Other:	
HIV / AIDS		
Liver disease / Hepatitis		
Muscle or joint pain		
Nail problems		
I understand the information above is an important part of my medical care and I have answered all of the above questions truthfully and to the best of my abilities.		
Patient or Guardian Sign Here X _____		Date _____
Initial History	Interval History	Review Date