Nashville Family Foot Care, PLLC

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: (Please mark any conditions that you have now or have been treated for in the past by a Physician.)

O Aids	O Depression	O Neuropathy	O Sexually Transmitted Disease
O Anemia	O Epilepsy	O Osteoarthritis	O Varicose Veins
O Angina	O Fibromyalgia	O Psychiatric Care	O Diabetes
O Artificial Implants	O Gout	O Rheumatic Fever	O Vascular Disease
O Asthma	O Heart Attack	O Rheumatoid Arthritis	O Liver Disease
O Back Injury	O Hepatitis	O Sickle Cell Disease	
O Bleeding Disorders	O High Blood Pressure	O Spina bifida	
O Blood clots	O High Cholesterol	O Stomach Ulcers	
O Cancer	O Irritable Bowel Syndrome	O Stroke	
O Chemical Dependency	O Kidney Disease	O Thyroid Disease	
O Circulatory Problems	O Lupus	O Tuberculosis	

SOCIAL HISTORY: Are you? O Employed O Unemployed O Disabled O Retired

Are you? O Married O Single O Widowed O Divorced

SMOKING STATUS: O Current O Never O Quit ALCOHOL USE: O Daily O Weekly O Socially O None

RECREATIONAL DRUG USE: O Never used O Current Use O Past Use

FAMILY HISTORY: O Diabetes O Heart Disease O Cancer O Hypertension O Circulatory Problem O Arthritis

Current Symptoms: (Describe your current symptoms)_____

_____

_____

Print Patient Name: Patient Signature:

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CURRENT REVIEW OF SYSTEMS: Please fill in the bubble to any conditions that you are currently experiencing:

Headaches	O YES O NO	Stomach Ulcers	O YES O NO	Anxiety	O YES O NO
Fever	O YES O NO	Abdominal Pain	O YES O NO	Muscle Weakness	O YES O NO
Dizziness	O YES O NO	Vomiting	O YES O NO	Leg Cramps	O YES O NO
Impaired Vision	O YES O NO	Diarrhea	O YES O NO	Numbness & Tingling	O YES O NO
Impaired Hearing	O YES O NO	Swelling in Legs	O YES O NO	Urinary Difficulty	O YES O NO
Difficulty in Walking	O YES O NO	Leg or Foot Pain	O YES O NO	Weight Loss	O YES O NO
Tremors	O YES O NO	Back Pain	O YES O NO	Other: _____	
Trouble Swallowing	O YES O NO	Chest Pain	O YES O NO	Other: _____	
Heartburn	O YES O NO	Shortness of Breath	O YES O NO	Other: _____	

Please list Prior Surgeries including Dates:

_____

_____

_____

_____

Medication and Other Allergies: (Please Include Reaction) _____

_____

_____

_____

_____

Please list all medications you are currently taking. Please list each one and how you are currently taking the medication. Please bring a current list to each appointment. We will update it each time you are seen in the office.

Name of Drug?	**Strength of Drug?**	**How often do you take?**	**For What Condition?**