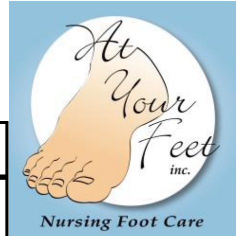
# Patient History




Today`s Date:

| Name: | ☐ Male ☐ Female ☐ Other | Date of Birth: |
|---|---|---|
| Address: | City: | Postal Code |
| Phone: (H) ( ) (O) ( ) | Province: | Email: |

| Occupation: Retired | Spouse's Name: |
|---|---|
| Emergency Contact: | Phone: (H) ( ) (O) ( ) |

Referred to the clinic by:

Reason For Visit:

**ALLERGIES:**

Doctor: Phone:

**MEDICATIONS:**

## MEDICAL HISTORY

☑ Please check the box for any conditions you currently have or had in the past.

- ☐ Diabetes I / II
- ☐ Lymphedema
- ☐ Arthritis/Rheumatism
- ☐ Osteoporosis
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Angina
- ☐ Irregular Pulse
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Thyroid: Hypo/Hyper
- ☐ Parkinson's Disease
- ☐ Tremor

- ☐ Dementia
- ☐ Nerve disorders
- ☐ Epilepsy
- ☐ Alzheimer's
- ☐ Weight Loss/Gain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Failing Vision
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Asthma/ Shortness of breath

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Phlebitis
- ☐ HIV/AIDS
- ☐ Bleeding disorders
- ☐ Muscle Weakness
- ☐ Numbness Tingling
- ☐ Keloid (Thick Scarring)
- ☐ Back pain ________
- ☐ Back problem
- ☐ Psoriasis
- ☐ Eczema
- ☐ Polio
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Psychiatric Disorder

- ☐ Bone Fracture/injury

Location:________________

- ☐ Psychiatric Disorder

________________

- ☐ Amputation ________
- ☐ Cancer(type):

________________

- ☐ Smoker:Years: _____
- ☐ Quit: Years: _____
- ☐ Never smoked

Height: ____________

Weight: ____________

☐ Surgeries & dates:

________________
________________
________________
________________
________________

☐ Pins, plates or screws from surgeries
Location:____________

☐Other:

________________
________________
________________
________________

## FOOT PROBLEMS

☑ Please check the box for any conditions you currently have or had in the past.

- ☐ Corns/Calluses
- ☐ Thick nails
- ☐ Thick deformed nails
- ☐ Ingrown nails
- ☐ Athletes foot
- ☐ Nail Fungus

- ☐ Swollen Ankles
- ☐ Cold Feet
- ☐ Foot Numbness
- ☐ Calf Pain
- ☐ Heel Pain
- ☐ Bruising easily

- ☐ Cramps in feet/legs
- ☐ Varicose Veins
- ☐ Leg Perthusis
- ☐ Knee Replacement R/L
- ☐ Hip Replacement R/ L
- ☐ Pins in feet/ankles/legs

- ☐ Bunion R/L
- ☐ Hammer toes R/L
- ☐ Neuroma
- ☐ Plantar Warts
- ☐ Club foot
- ☐ Childhood foot problems

- ☐ Amputation: ________
- ☐ Broken Foot Bones
- ☐ Arthritis
- ☐ Neuropathy
- ☐ Charcot foot
- ☐ Do you wear Orthotics?

**Are You Presently being treated by a Health Care professional for anything?** ☐ NO ☐ YES If YES Please Describe:

**Hobbies / Recreational Activities:**

**At Your Feet Nursing Foot Care**
**408 West 5th St.**
**Hamilton, ON L9C 3P6**

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