Alm Foot Care

MEDICAL & SURGICAL TREATMENT OF FOOT DISORDERS

Patient Name

Birth date

MEDICAL HISTORY

Please check Yes or No for each item.

EYE	Y	N
Glaucoma	☐	☐
Visual Impairment	☐	☐

ENDOCRINE	Y	N
Diabetes	☐	☐
If yes, indicate how many years		
Thyroid disorder	☐	☐

RESPIRATORY	Y	N
Shortness of breath	☐	☐
Asthma	☐	☐
COPD (Chronic Obstructive Pulmonary Disorder)	☐	☐

GASTROINTESTINAL	Y	N
History of stomach ulcer	☐	☐
GERD	☐	☐

GASTROURINARY	Y	N
Recurring urinary tract infection	☐	☐
Kidney failure	☐	☐
Dialysis	☐	☐

IMMUNOLOGICAL	Y	N
Prior organ transplant	☐	☐
HIV	☐	☐
AIDS	☐	☐

NEUROLOGICAL	Y	N
Prior stroke	☐	☐
Prior TIA	☐	☐
Neuropathy	☐	☐
Seizure disorder	☐	☐
Parkinson’s disease	☐	☐
Anxiety	☐	☐
Depression	☐	☐

CARDIOVASCULAR SYSTEM	Y	N
High blood pressure	☐	☐
Irregular heart beat, palpitations	☐	☐
Heart murmur	☐	☐
Mitral valve prolapse	☐	☐
CHF (Congestive Heart Failure)	☐	☐
Prior heart attack	☐	☐
Pacemaker or defibrillator	☐	☐
Prior heart surgery	☐	☐
On warfarin/coumadin	☐	☐
Pain in legs or leg cramps while walking 1-2 blocks	☐	☐

MUSCULOSKELETAL SYSTEM	Y	N
Arthritis (osteoarthritis)	☐	☐
Rheumatoid arthritis	☐	☐
Gout	☐	☐
Other types of arthritis	☐	☐
Joint replacement surgery	☐	☐
Surgical repair of broken bones	☐	☐
Prior foot surgery	☐	☐
Spine disorders	☐	☐
Fibromyalgia	☐	☐
Chronic pain syndrome	☐	☐

SOCIAL HISTORY	Y	N
Employed	☐	☐
Retired	☐	☐
Do you drink alcoholic beverages	☐	☐
Do you use tobacco products	☐	☐

Please check if condition pertains to mother (M), father (F), sisters (S) or brothers (B).

FAMILY HISTORY	M	F	S	B
Diabetes	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Kidney disorder	☐	☐	☐	☐

KEY ALLERGIES	Y	N
Latex	☐	☐
Penicillin	☐	☐
Local anesthetics (novacaine)	☐	☐

MISCELLANEOUS	Y	N
Do you take antibiotics prior to dental care?	☐	☐
Do you have a bleeding disorder?	☐	☐
Women, to your knowledge, are you pregnant?	☐	☐

To the best of my knowledge, the above information is accurate and complete.

Patient or Guardian Signature ______________________ Date ______________

(for office use only)

POSITIVE FINDINGS

I have reviewed this completed form with the patient or guardian.

Practitioner Signature ______________________ Date ______________