Medical Intake Form

Fit Feet For Life **Carillon/St. Petersburg/Sun City Center/Tampa/Town N' Country** **(813) 645-1993 (727) 824-5100**

Reason for Visit (please explain): □ Other

□ Foot/Toe pain □ Ugly/Ingrown nails □ Rash/Itching feet □ Wart □ Hard/Thick skin □ Cracked heels □ Medical Pedicure

Primary Care Physician (name, address, phone/fax):

Height: ft___in____ Weight: ______ lbs. Shoe Size: ____Width:__.

Please list your **CURRENT MEDICATIONS:** including blood thinners, vitamins, supplements and herbals. (Use back if needed)

ALLERGIES TO MEDICATIONS list or circle **NONE**: ____

Family History: (incl. Diabetes, hypertension, heart disease, cause of death an **Siblings:** ________________

Father: _______________________ **Mother:** __________________ □ living □ deceased ____age

□ living □ deceased ____age □ living □ deceased ____age □ living □ deceased ____age

Social History: **Marital Status**: □ single □ married □ widowed □ divorced

Alcohol Use: □ none □ occasional □ moderate □ heavy **Tobacco Use**: □ never □ former □ current smoker ___ # years smoked

Occupation □ current □ retired (most recent): **Drug use not prescribed by a doctor**: □ yes □ never

Please list any recent (past 3 years) or relevant (lower extremity) **SURGERY with dates**: (Use back if needed)

Medical History: **Do you have a history of falls?** □ NONE # in past year __ Were you injured □ Yes □ No

	Yes	No		Yes	No		Yes	No
Arthritis	□	□	High blood pressure	□	□	Other infectious disease	□	□
Blood thinners	□	□	Stroke/TIA	□	□	Gout	□	□
Diabetes	□	□	HIV/AIDs	□	□	Implants	□	□
Cancer ____________	□	□	Hepatitis A / B / C	□	□	(incl. Stent & Cataract)		

Review of Systems: Please indicate whether or not you are experiencing or under treatment for the following:

Constitutional	Yes	No	**Dermatological**	Yes	No	**Eyes**	Yes	No
Good General Health:	□	□	Changes in skin or nails	□	□	Wear glasses/contacts	□	□
Recent Weight Change:	□	□	Rashes or itching	□	□	Glaucoma	□	□
Fatigue	□	□	Skin cancer	□	□	**Gastrointestinal**		
Cardiovascular			**Ear/Nose/Mouth/Throat**			Bloody stool	□	□
Heart Problems	□	□	Hearing loss	□	□	Loose stool	□	□
Calf pain: Resting	□	□	Ringing	□	□	Constipation	□	□
Walking	□	□	Dry Mouth	□	□	**Endocrine**		
Swelling: General	□	□	**Respiratory**			Excessive thirst	□	□
Hands	□	□	Shortness of breath	□	□	High blood sugar	□	□
Feet	□	□	Asthma	□	□	Low blood sugar	□	□
Musculoskeletal			COPD	□	□	Thyroid disease	□	□
Weakness	□	□	**Allergic/Immunologic**			Hormone imbalance	□	□
Muscle pain/cramps	□	□	Antibiotic allergies	□	□	**Genitourinary**		
Joint pain	□	□	Allergies to medications	□	□	Incontinence	□	□
Trouble walking	□	□	Autoimmune disease:	□	□	Frequent urination	□	□
Neurological			**Hematologic/Lymphatic**	□	□	**Psychiatric**		
Numbness in Hands / Feet	□	□	Bruise easily	□	□	Insomnia	□	□
Tingling in Hands / Feet	□	□	Slow to heal	□	□	Confusion / Memory Loss	□	□
Burning in Hands / Feet	□	□	Bleeding/Clotting disease	□	□	Depression	□	□

Please indicate here to see additional details included on back of this form: □

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

Print Name: ______________________________

X Signed: ______________________________ date ____________

Physician Statement: I have reviewed the questionnaire.

X Signed: ______________________________ date ____________