**Foot Care Health History**

For Your information:

An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information.

Current Allergies & Medications:

**Health History:** Please indicate conditions you are experiencing or have experienced.

|  |  |  |
| --- | --- | --- |
| **Respiratory**  * Chronic cough
* Shortness of breath
* Bronchitis
* Asthma
* Emphysema
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular*** High blood pressure
* Low blood pressure
* Congestive Heart Failure
* Heart attack/MI
* Circulation Issues
* Stroke/CVA
* Edema
* Pacemaker or similar device
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History*** Arthritis
* Cancer
* Diabetes
* Heart disease/ stroke
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **Other Conditions*** Diabetes: onset \_\_\_\_\_\_\_
* Cancer
* Arthritis
* Migraines &/or headaches
* Loss of sensation
* Vision problems
* Vison loss
* Ear problems
* Hearing loss
* Skin conditions
* Hepatitis
* TB
* HIV
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cigarette/ Tobacco Consumption*** Yes- amount \_\_\_\_\_/ day
* no
 | **Women*** pregnant: due: \_\_\_\_\_\_\_\_

**Soft Tissue/ Joint Discomfort*** Neck
* Low back
* Mid back
* Upper back
* Shoulders
* Arms
* Hands
* Hips

Legs* Knees
* Feet
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rate your General Health*** Above average
* Average
* Below average
 |

What concerns you about your feet?

Have you had any major surgeries or injuries to your lower legs or feet? **YES NO**

If yes, please explain:

Ambulatory Aids? Circle any of the following: WALKER CANE WHEELCHAIR

Do you have a history of falls within the last year? YES NO

If yes, please explain:

**Patient Signature:** **Date:**

**Foot Care Nurse:** **Date:**