PREMIER
FOOT & ANKLE CARE

Name: _____

DOB: _____/_____/_____

Height: _____

Weight: _____

PATIENT MEDICAL HISTORY:
(Please check all that apply)

- Arthritis (Osteo/Psoriatic/Rheumatoid)
- Asthma/COPD/Emphysema
- Bleeding Problems/Disorders
- Blood Clots/DVT
- Cancer: Type _____
- Circulation Problems
- Depression
- Diabetes
- Gout
- Heart Disease
- Hepatitis: Type _____
- High Blood Pressure
- HIV/AIDS
- Kidney Disease
- Liver Disease
- Neuropathy
- Seizure Disorder
- Stomach Ulcers
- Stroke
- Other:

_____
_____
_____

REASON FOR YOUR VISIT:

_____
_____

SURGICAL HISTORY:

_____
_____
_____
_____

FAMILY MEDICAL HISTORY:
(Please check all that apply)

- Arthritis
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Stroke

SOCIAL HISTORY:

Smoke: YES NO Years:_____
Alcohol: YES NO
Drug Use: YES NO

SHOE SIZE: _____

MEDICATIONS: Please list name & dose OR provide a medication list

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: Please list allergies to medications/tapes/latex/etc

_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last month.

General:
- Fever
- Chills/Excessive Sweating
- Loss of Appetite
- Unexplained Weight Loss/Gain

Endocrine:
- Excessive Thirst or Hunger
- Fatigue
- Excessive Hot /Cold

Cardiovascular:
- Chest Pain
- Swelling of Feet, Ankle or Legs
- Palpitations
- Cramping in Legs

Gastrointestinal:
- Abdominal Pain
- Nausea/Vomiting
- Diarrhea
- Constipation

Psychological:
- Depression
- Anxiety

Hematologic:
- Easy Bruising
- Clotting Issues

Skin:
- Rash
- Itching
- Lumps or Masses
- Skin Discoloration

Musculoskeletal:
- Joint Pain
- Joint Swelling
- Difficulty Walking

Neurological:
- Numbness or Tingling
- Dizziness
- Weakness

Patient/Guardian Signature: _____

Physician Signature: _____