CRIMSON FOOT CARE • 4124 Watermelon Road, Suite A, Northport, AL 35473 • Phone: 205-409-0175 • Fax: 205-764-5800

HEALTH HISTORY

Name ____ Date of Birth (MM/DD/YYYY) __________________

Why are you seeing the doctor today? ____

Weight: ________________ Height: ___________________ Shoe Size: _______________________________________

Allergies: □ No Known Drug Allergies □ Adhesive / Tape

□ Codeine □ Iodine

□ Penicillin □ Sulfa

□ Latex □ Local Anesthetic

□ Other _________________________________

Medications: (include herbal, vitamins, & supplements)

Name of Medication	Mg/Strength	Dose

Past Medical History

Surgeries / Hospitalization	Year

Do you currently have or have you had problems with:

Anemia	□ Yes □ No	Foot/Leg Cramps	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Arthritis	□ Yes □ No	Gout	□ Yes □ No	Scarring Tendency	□ Yes □ No
Artificial Valve or Joint	□ Yes □ No	Headaches	□ Yes □ No	Shortness of Breath	□ Yes □ No
Asthma	□ Yes □ No	Heart Disease	□ Yes □ No	Skin Problems	□ Yes □ No
Back Problems	□ Yes □ No	Hemophilia	□ Yes □ No	Stomach Problems	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Hepatitis	□ Yes □ No	Stroke	□ Yes □ No
Cancer	□ Yes □ No	High Blood Pressure	□ Yes □ No	Swelling in Ankle/Feet	□ Yes □ No
Chest Pain	□ Yes □ No	High Cholesterol	□ Yes □ No	Thyroid Problems	□ Yes □ No
Chills	□ Yes □ No	Joint Pain or Stiffness	□ Yes □ No	Tired Feet	□ Yes □ No
Circulatory Problems	□ Yes □ No	Kidney Problems	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes: □T1 □T2 ___yrs.	□ Yes □ No	Liver Disease	□ Yes □ No	Ulcers in foot or leg	□ Yes □ No
Ear problems	□ Yes □ No	Mental Disorder	□ Yes □ No	Varicose Veins	□ Yes □ No
Epilepsy	□ Yes □ No	Muscle Aches	□ Yes □ No	Weight Loss, unexplained	□ Yes □ No
Fever	□ Yes □ No	Radiation Treatment	□ Yes □ No	Other ______________________	

Social History

□ Employed □ Unemployed □ Disabled □ Student □ Retired Children: □ No □ Yes, how many _______________

Do you use tobacco? □ No □ Yes Do you smoke cigarettes? □ No □ Yes: how much_____________ how long __________

Previously a smoker? □ No □ Yes: quit for _____________ years

Do you drink alcohol? □ No □ Yes: frequency _________ type ___________ Drug Use □ No □ Yes type ____________

Exercise: □ Daily □ Weekly □ Monthly □ Rarely □ Never If so, what type? ________________________________

Family History: Has anyone in the family been diagnosed with the following disease? If yes, please indicate which family member

Cancer	□ Yes □ No	__________________	Heart Disease	□ Yes □ No	__________________
High Blood Pressure	□ Yes □ No	__________________	Diabetes	□ Yes □ No	__________________

Patient Signature: ____________________________________ Date: ______________________________________

FOR OFFICE STAFF

Reviewed by: _____________________________________ Date: ______________________________________