Advanced Footcare Inc.
2980 Aventura Blvd ▪Aventura, FL 33180
Phone: 786-428-3668 ▪ Fax: 305-932-0922

HEALTH HISTORY

Review of Systems: **Name:** **Date**

General	Respiratory	Musculoskeletal
		Y N Arthritis/Joint Pain
Y N Recent Weight Loss	Y N Chronic Cough	Y N Back Pain
Y N Fever	Y N Asthma/Wheezing	Y N Muscle Pain
Y N Chronic Fatigue	Y N Shortness of Breath	
Y N Anemia	Y N Frequent Infections	**Skin**
Y N Bruise Easily		Y N Rashes/Hives
Y N Allergies		Y N Itching
______________________________	**Genitourinary**	
		Ear, Nose< Throat
________________________________	Y N Frequent Urine Infections	Y N Ringing in Ears
	Y N Blood in Urine	Y N Ear Infection
Eyes	Y N Painful/Frequent Urination	Y N Loss of Hearing
	Y N Discharge	Y N Hoarseness
Y N Failing Vision	Y N Sexual Dysfunction	Y N Voice change
Y N Eye Infections	Y N Abnormal Period (female)	Y N Mucus in Throat
Y N Double Vision	Date of last normal menstrual period:	Y N Sinus Trouble
Y N Blury Vision	________________________________	N Y Nose Bleeds
	Y N Any chance of being pregnant now?	N Y Sore Throat
Cardiovascular	Y N Prostrate Trouble (Males)	
		Psychiatric
Y N Chest Pain	**Neurological**	
Y N Dizziness/Fainting		Y N Nervousness
Y N Palpitations	Y N Convulsion/Seizure	Y N Depression
Y N Swollen Ankles	Y N Tremor/Hands Shake	Y N Memory Loss
Y N Leg Pain Walking	Y N Muscle Weakness	Y N Trouble Sleeping
Y N Varicose Veins	Y N Numbness/Tingling	
	Y N Frequent Headaches	

Past Medical / Surgical History

Have you had any of these diseases?

Y N High Blood Pressure	Y N Dialysis
Y N Diabetes	Y N High Cholesterol / Triglycerides
Y N Stroke	Y N Thyroid Disease
Y N Chronic Bronchitis	Y N HIV
Y N Asthma	Y N Breast Cancer
Y N Epilepsy	Y N Prostrate Cancer
Y N Renal Failure	Y N Migraines
Y N Arthritis (DJD___RA____Osteo___Other___)	Other Cancers?____
Y N Heart Disease (MI___Angina___Arrhythmias___ Valve___Other___) ____	Other Diseases? ____ ____

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Have you had any of these surgeries?

Y N Tonsils
Y N Appendix
Y N Gallbladder
Y N Hernia
Y N Back Surgery
Y N Skin (Biopsy---Cancer___)
Y N Hysterectomy
Y N Tubal Ligation

Y N C-Section
Y N Breast Surgery (Biopsy___Mastectomy___)
Y N Orthopedic Surgery
Y N Minor Surgery
Y N Prostate Surgery (Radical___TURP___)
Other Surgeries____

Do you take any medicines? If so…list______________________________

Are you Allergic to any medicines? If so, list______________________________

FAMILY HISTORY

Please indicate relation: Father, Mother, Siblings, Father's Parents, Mother's Parents

Y N Colon Cancer ______________________________
Y N Colon Polyps ______________________________
Y N Other gastrointestinal Cancer ______________________________
Y N Ulcers ______________________________
Y N Gallstones ______________________________
Y N Ulcerative Colitis ______________________________
Y N Crohn's Disease ______________________________
Y N Other Cancer ______________________________
Do any other diseases run in your family?______________________________

SOCIAL/PERSONAL HISTORY

☐ Married
☐ Single
☐ Widowed
☐ Divorced
☐ Other:

Y N Tobacco
Y N Alcohol
Y N Drugs

Y N Transfusions
Y N Tattoos
Y N Occupational Exposure
Y N Travel:

Living Status:
☐ Alone
☐ Caretaker
☐ Nursing Home or ACLF
☐ Family/Spouse/Friend