Medical History Intake Form

Thank you for taking the time to fill out our Intake form. We ask for information about your medical history to help us treat you safely. Please fill out the questions below to the best of your knowledge, including a list of your current medications and bring it with you to your first appointment or email it to OSAATfootcareclinic@gmail.com.

***All information will be kept strictly confidential.**

Client Name:_____ (Please Print)Date of Birth: ___/___/_____ (D/M/Y)

Age: _____ Gender: ____M ____F Health Card Number: _____

Mailing Address: _____ Postal Code: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Allergies: _____

Marital Status: Single___ Married____ Common-law____ Widowed ___ Separated ___ Divorced___

Occupation (How you spend your time):_____

List of Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Check off any of the following conditions that apply to you, either presently or previously.

□ Back and/or Leg/Foot Pain □ Vision Problems □ Cataracts/Glaucoma, etc.

□ Neck and/or Arm/Hand Pain Specify: _____ □ Deep Vein Thrombosis

□ Hearing Problems □ Wears Ai □ Dementia or Memory Problems □ Depression/Anxiety/etc.

□ Autoimmune Disease Specify: _____ □ Hepatitis B or C

□ Seizures □ High Blood Pressure □ GI, Stomach or Bowel Problems

Initial pg 1:_____

□ Thyroid Disorder □ Low Blood Pressure Specify: _____

□ Type I Diabetes □ Type II Diabetes Insulin, Specify: _____

□ Coronary Artery or Heart Disease □ Kidney or Urinary Problems

□ Peripheral Artery Disease □ Other Heart/Circulatory Conditions
Specify: _____

□ Multiple Sclerosis □ Osteoarthritis □ Neuromuscular Disorders
Specify: _____

□ Rheumatoid Arthritis □ Stroke or TIA □ Other Inflammatory Conditions
Specify: _____

□ Cancer Specify: _____ □ Chemotherapy Past/Present

□Alcohol Use Specify: _____ How Long: _____

□ Chronic Fatigue Syndrome □Nicotine Use How Long: _____

□ Marijuana Use How Long: _____

□ Unintended Weight Gain/Loss How Much: _____

□ Tendonitis □ Skin Diseases □ Varicose Veins □ Venous Insufficiency

□ Asthma, Bronchitis, COPD, or other Respiratory Problems

□ Diet/Missing Food Groups Specify: _____ □ Anemia

□ Foot Deformity Specify: _____

□ Neurological Disorders/Disease Specify: _____

□ Blood Disease/Disorder Specify: _____

□ Surgery Specify: _____ □ Other Specify: _____

Notes: _____

_____

_____

_____

_____

_____

_____

This medical history is complete to the best of my knowledge and I understand that a thorough medical history is necessary to provide safe and holistic nursing care.

Name (Please Print): _____ Date: _____

Signature: _____