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](mailto: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:

Email 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.***

***○*** Vision Problems ***○*** Cataracts/Glaucoma, etc Specify:

***○*** Neck and/or Arm/Hand Pain ***○*** Back and/or Leg/Foot Pain ***○*** Sore Joints

***○*** Hearing Problems ○ Wears Heading Aids ○ Seizures ○ Dementia or Memory Problems

○ Depression/Anxiety/etc. ○ Hepatitis B or C ○ High Blood Pressure ○ Low Blood Pressure

○ Deep Vein Thrombosis ○ Autoimmune Disease Specify:



○ Thyroid Disorder ○ GI, Stomach or Bowel Problems 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 ○ Stroke or TIA ○ Chronic Fatigue Syndrome

○ Neuromuscular Disorders Specify:

○ Other Inflammatory Conditions Specify:

○ Cancer Specify: How Long:

○ Alcohol Use Specify: How Long:

○ Nicotine Use How Long: ○ Marijuana Use How Long:

○ Unintended Weight Gain/Loss How Much:

○ Asthma, Bronchitis, COPD, or other Respiratory Problems ○ Anemia

○ Diet/Missing Food Groups Specify:

○ Varicose Veins ○ Venous Insufficiency ○ Foot Deformity Specify:

○ Skin Disease ○ Neurological Disorder/Disease Specify:

○ Tendonitis ○ 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:

