Welcome to Our Office
404-334-0696
404-995-7720 fax
www.famfootcare.com

Name: _____ Date of Birth:_____/_____/_____

Reason For Visit: Toe/ Foot Pain Ankle Pain Leg Pain Swelling Skin Condition _____

- **List or attach a complete list of all current Medications:**

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**Past Medical History**

| | |
|---|---|
| Diabetes | Cancer |
| Hypertension | Kidney Disease/ Dialysis |
| Hyperlipidemia | |
| Coronary Disease | |
| Thyroid Condition | |
| Stroke | |
| Dementia | |

**Age: _____ Weight: _____**

**Height:_____ B/P:_____/_____**

**Primary Physician_____**

**Physician Contact# (_____)__ _____**

**Pharmacy_____**

**Allergies:** ❑ None ❑ Penicillin ❑ Sulfa ❑ Aspirin ❑ Contrast ❑ Latex ❑ Iodine ❑ Tape ❑ Shellfish ❑ Gluten intolerance ❑ Food ❑ Metal Other:_____

**Surgeries/ Dates:**

| | | |
|---|---|---|
| ❑ Tonsils / adenoids | ❑ Amputation | ❑ Other vascular bypass |
| ❑ Appendix | ❑ Gallbladder | ❑Foot Surgery: |
| ❑ Hysterectomy | ❑ Hernia | ❑ Other: _____ |
| ❑ Angioplasty (balloon/stent) | ❑ Coronary (heart) bypass | |

**Family Medical History?** Father:_____Mother:_____

Have you ever used illicit drugs? ❑ Y ❑ N Do you ever drink alcohol? ❑ Y ❑ N
Have you ever used tobacco? ❑ Y ❑ N Currently Smoking: Yes / No

Patient Signature_____ Email_____

**Complete 2nd Page**

Atlanta Family FOOT CARE

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# Blood Flow/ Circulation Questionnaire

**Name (Please Print)_____**

(Please Circle Your Answer)

Do you have pain or cramping in the muscles of your buttock, thigh, or calf when you walk?

Yes No

Do you have pain in the muscles of your buttock, thigh, or calf when you climb stairs?

Yes No

Do you wake up at night due to burning and tingling in your feet

Yes No

Do you or have you had a wound or sore on your feet/leg that is slow to heal?

Yes No

Do you have leg swelling or varicose veins?

Yes No

Do you have leg pain at rest?

Yes No

Have you previously had stents placed in your legs or heart OR have you previously had bypass surgery in your legs or heart?

Yes No

Have you been diagnosed with coronary artery disease, carotid artery disease (arteries in the neck), and/or kidney artery disease?

Yes No

Have you previously had a heart attack?

Yes No

Have you ever been told you have poor pulses in your feet?

Yes No

Patient Signature_____