On UR Feet
Advanced Foot Care Nursing Services
Specializing in Diabetes

CLIENT INTAKE/HEALTH HISTORY FORM

Name _____ Sex _____ D.O.B. _____

Address _____

Phone # _____ Cell# _____ Email _____

Family Dr. _____ Phone# _____ Fax# _____

Occupation _____ Height _____ Weight _____ Shoe size _____

Allergies _____ Do you smoke? _____ How many years? _____

Check the following medical conditions that apply: ☐ heart disease ☐ stroke ☐ respiratory

☐ cancer ☐ osteoporosis ☐ arthritis Others: _____

Check if you are taking any of the following medications: ☐ anti coagulants (blood thinners) ☐ steroids

☐ non-steroidal anti-inflammatories ☐ antibiotics ☐ diuretics (water pill)

List any surgeries _____

Health history pertinent to foot care _____

Today's foot concerns _____

Previous foot care experience _____

Who has been caring for your feet? _____

How did you hear about us? _____ May we thank someone for the referral? _____

Any history of falls? (explain) _____

Check any mobility aids used: ☐ cane ☐ walker ☐ wheelchair. Other: _____

Are you a diabetic? _____ (if NO please proceed to line marked with*) How many years? _____

Are you on Insulin? _____ List type _____

Do you take oral medication? _____ List type _____

How often do you check your blood sugar? _____ BS range _____

How often do you check your Hemoglobin A1C? _____ Last result _____

*Any history of leg ulcers? (explain) _____

Any issues with your circulation? (i.e. PVD) _____

Any loss or altered sensation? (numbness, tingling, burning, pins and needles) _____

Signature: _____ Date: _____