Nashville Family Foot Care, PLLC

Patient Name: Date of Birth:

CURRENT REVIEW OF SYSTEMS: Please fill in the bubble to any conditions that you are currently experiencing:

Headaches	O YES O NO	Stomach Ulcers	O YES O NO	Anxiety	O YES O NO
Fever	O YES O NO	Abdominal Pain	O YES O NO	Muscle Weakness	O YES O NO
Dizziness	O YES O NO	Vomiting	O YES O NO	Leg Cramps	O YES O NO
Impaired Vision	O YES O NO	Diarrhea	O YES O NO	Numbness & Tingling	O YES O NO
Impaired Hearing	O YES O NO	Swelling in Legs	O YES O NO	Urinary Difficulty	O YES O NO
Difficulty in Walking	O YES O NO	Leg or Foot Pain	O YES O NO	Weight Loss	O YES O NO
Tremors	O YES O NO	Back Pain	O YES O NO	Other: ___________________________	
Trouble Swallowing	O YES O NO	Chest Pain	O YES O NO	Other: ___________________________	
Heartburn	O YES O NO	Shortness of Breath	O YES O NO	Other: ___________________________	

Please list Prior Surgeries including Dates:

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Medication and Other Allergies: (Please Include Reaction) _________________________________

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Please list all medications you are currently taking. Please list each one and how you are currently taking the medication. Please bring a current list to each appointment. We will update it each time you are seen in the office.

Name of Drug?	**Strength of Drug?**	**How often do you take?**	**Prescribed by?**