

COMPLETE FOOT AND ANKLE CARE OF NORTH TEXAS

Medical History Form  
for Diabetic Patients

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Date: \_\_\_\_\_

How long have you had Diabetes? \_\_\_\_\_ years, \_\_\_\_\_ months

Does anyone in your family have Diabetes? Y or N (circle)

Family member relationship: \_\_\_\_\_

Have you ever had an open wound or ulcer on your foot? Y or N

If so, how long did it take you to heal it? \_\_\_\_\_

Have you ever had an amputation? Y or N (circle)

If so, What was amputated? \_\_\_\_\_

Do you use any assistive devices to get around or walk? Y or N

If so, What? (Please Circle)

Walker / Wheelchair / Brace or Boot / Cane / Roll- About

Do you **currently** smoke or use tobacco? Y or N

If so, what do you smoke? (circle) Cigarettes / Cigars / Snuff / Dip / Other

How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Did you smoke or use tobacco in the past? Y or N (circle)

If so, when did you quit? \_\_\_\_\_ years ago, \_\_\_\_\_ months ago

Have you ever had a lower extremity vascular/circulation test performed?

If so, when? \_\_\_\_\_

Do you have any of the following sensations in your feet?

Numbness / Tingling / Sharp shooting / Burning / Electrical

Have you ever had any nerve testing performed? Y or N

Have you ever seen any other Podiatrists? Y or N, If So, Who? \_\_\_\_\_

And When? \_\_\_\_\_

