PATIENT INFORMATION

Date _____

Patient No. _____

Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Pager _____ email _____

Birth Date _____ Age _____ Sex _____ Weight _____ Height _____ Shoe Size _____

Check appropriate box ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

If student, name of College/School _____ ☐ Full Time ☐ Part Time

Patient Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____

Spouse's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Person and Phone to contact in an emergency _____

Who is responsible for this account? _____

RESPONSIBLE PARTY INFORMATION FOR MINORS

Name of Mother _____

Birth date _____ SS# _____

Employer _____ City _____ State _____ Zip _____

Work Phone _____

Name of Father _____

Birth date _____ SS# _____

Employer _____ City _____ State _____ Zip _____

Work Phone _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

1. Are you under medical treatment now? ☐ Yes ☐ No _____
2. Have you been hospitalized or had any surgeries? ☐ Yes ☐ No Explain _____

_____

3. Are you diabetic? ☐ Yes ☐ No

Please list allergies and reactions:

_____

_____

_____

Please list all medications, dosages, and conditions prescribed for:

_____

_____

_____

_____

For multiple medications, please write on the back.

WOMEN ONLY:

1. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
2. Are you nursing? ☐ Yes ☐ No
3. Are you taking oral contraceptives? ☐ Yes ☐ No
4. Menopause? ☐ Yes ☐ No
5. Pregnancies_____ Births _____

PAST MEDICAL HISTORY

Have you ever been treated for any of the following illnesses? (if yes, please check.)

☐ High Blood Pressure	☐ Immunodeficiency Disease or HIV	☐ Liver Disease
☐ Heart Disease/Heart Attack	☐ Diabetes	☐ Rheumatic Fever
☐ Stomach or Digestive Problems	☐ Cancer	☐ Neurological Problems
☐ Respiratory/Breathing Problems	☐ Arthritis	☐ Circulation Problems
☐ Psychiatric Disorders	☐ Ulcers	☐ Thyroid Problems
☐ Epilepsy/Seizures	☐ Stroke	☐ TB
☐ Joint Replacement	☐ Hepatitis	☐ Cholesterol Problems
☐ Heart Valves or Pacemaker	☐ Phlebitis	☐ STD's

Please comment on any illness checked above or write in other conditions _____

_____

_____

Is your Tetanus up to date? ☐ Yes ☐ No

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced

Children: ☐ No ☐ Yes – Number and age(s) _____

I live: ☐ Alone ☐ With someone

Alcohol Use _____ If so, (circle amount) 1-6 6-12 12-18 18+ drinks per week

Tobacco Use _____ # of packs per day: _____

Type of work _____

FAMILY HISTORY

Are there any diseases that run in your family (i.e. diabetes, rheumatoid arthritis, bleeding disorders or anesthetic complications such as malignant hyperthermia)? _____

_____

_____

Mother – Alive or Deceased

If deceased, cause _____

Father – Alive or Deceased

If deceased, cause _____

REVIEW OF SYSTEMS (Circle all that apply to you within the last two years)

Constitutional Symptoms (fever, weight loss, double vision, fatigue)

Explain _____

Eyes (double vision, blurring, glasses)

Explain _____

Ear, Nose, Throat & Mouth (deafness, sinusitis, hoarseness,vertigo)

Explain _____

Cardiovascular (chest pain, palpitations)

Explain _____

Respiratory (shortness of breath, asthma, cough)

Explain _____

REVIEW OF SYSTEMS (Continued)

Stomach/Intestinal (loss of appetite, weight change, diarrhea, constipation, abdominal pain)
Explain _____

Urology (hesitancy, incontinence, burning urination, menstrual problems)
Explain _____

Muscular Skeletal (fracture, sprain, joint pain/swelling, arthritis)
Explain _____

Skin/Breast (rashes, lesions, scars)
Explain _____

Neuro (speech, swallowing problems, stroke, seizures, headaches)
Explain _____

Psych (depression, hallucinations, sleep disturbances)
Explain _____

Endocrine (growth/hair changes, excess thirst, decreased energy)
Explain _____

Hematologic/Immunologic (easy bruising, blood clots, bleeding disorders)
Explain _____

Please answer the following questions to the best of your knowledge:

COMPLAINT (in your own words, explain what you feel your foot problem is): _____

_____

_____

_____

Result of an accident ? _____ If so, work related? _____ Work Comp filed? _____
Date of injury _____
Has any treatment been tried for this problem? If so, please described _____

_____

Please check any other foot problems you want to discuss with the doctor:

☐ Hammer Toes ☐ Foot Odor ☐ Excess Foot Perspiration

☐ Athletes Foot ☐ Bunions ☐ Fungal Nails

☐ Other: _____

THE INFORMATION SUPPLIED IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____