Patient Information

Date: _____

Name:_____/_____/_____
Last First Middle

Mailing Address:
_____
_____
_____
_____
E-mail address: _____

Cell Phone_____
Home Phone_____Work phone_____
Male____ Female____ Age___ Birthdate__/__/__
Place of Employment _____

Marital Status ____ Spouses Name_____
Spouses Date of Birth __/__/____Spouses Employment _____ Work Phone _____
If Child, list parents or guardians name: _____

Family Physician: _____
Last visit to Family physician on date: ____/___/_____
In case of emergency call _____ phone number _____

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Please bring cards to receptionist for copying or fill out the following:

Insurance Information

Insurance Holders Name _____
Insurance Holders Birthdate _____/____/_____ Insurance Holders Phone _____
Insurance Holders Address
_____
_____
_____

Name of Insurance Company _____
Address of Insurance Company _____
Policy Number _____
Group Number _____

Preferred Language _____, Race please circle: African American, Asian, Caucasian, Hispanic, Other

How did you hear about us?
Friend_____ Google_____ Internet_____Facebook_____
Doctor_____ Yellow Pages_____Twitter_____Other_____

Signature of Responsible Party _____

Current Medical Conditions:

Do you have or have had any of the following:

	YES	NO
Anemia	_____	_____
Arthritis	_____	_____
Circulation Problems	_____	_____
Chronic Disease	_____	_____
Diabetes	_____	_____
Heart Condition	_____	_____
Hepatitis	_____	_____
Hypertension	_____	_____
Kidney Problems	_____	_____
Liver Problems	_____	_____
Rheumatic Fever	_____	_____
Ulcers	_____	_____
Are You Pregnant?	_____	_____

Family History:

Does any close relative have:

Diabetes: Mother___Father___
Hypertension: Mother___ Father___
Heart Condition: Mother___Father___
Arthritis: Mother___Father___
Chronic/genetic: Mother___Father___

Social History:

Do you smoke now____If yes, how much___
Have you ever smoked_____when did you quit____

Do you drink____ If yes, how much_____
Do you exercise_____
Sports Activities_____

Previous surgery and hospitalizations:

Please list all surgeries and hospitalizations please include reasons and dates:

_____
_____
_____
_____

Medications:

Please list all medications you are taking:
(Please include dosage)

_____
_____
_____
_____
_____

Are you on Blood Thinners?_____

Allergies:

Codeine Yes_____ No ____
Keflex Yes_____ No _____
Penicillin Yes_____ No _____
Sulfa Yes_____ No _____
Local Anesthetics Yes_____ No _____
Other _____
_____

In your own words, please explain you chief problem with your feet:

_____
_____

I accept the ultimate responsibility for payments of fees to the doctor unless other written agreements have been made. I allow doctor to file insurance claims. I further agree that the history given above is true.

Signature of Responsible Party: _____

Review of Health

Please circle any condition or disease that may apply to you:

Cardiovascular
Angina
Angioplasty
Heart Attack
Heart Murmur
Hypertension
Irregular Heart
Mitral Valve Prolapse
Open Heart Surgery
Pacemaker

Endocrine
Diabetes
Osteoporosis
Thyroid

Gastrointestinal
Cirrhosis
Diverticulitis
Gallbladder
Hepatitis
Irritable Bowel
Reflux Esophagitis
Ulcers

HEENT
Cataracts
Dentures
Glaucoma
Headaches
Hearing Loss
Nasal Polyps
Neck Stiffness
Sinus Problems
Tinnitus
Vertigo
Vision Problems

Immunological
Epstein Barr
HIV or AIDS
Weakened Immune

Musculoskeletal
Collagen Disease
Arthritis
Fibromyalgia
Rheumatoid Arthritis

Neurological
Alzheimer's
Back Problems
Multiple Sclerosis
Parkinsonism
Scoliosis
Seizures
Stroke

Renal
Bladder Infections
Dialysis
Kidney Stones
Nephritis
Renal Failure
Transplant Kidney

Respiratory
Asthma
Breathing Problems
COPD
Emphysema
Chronic Lung Infections
Pleurisy
Tuberculosis

Skin
Contact Dermatitis
Dry Scaly Patches
Fungal Nails
Infection Skin
Nevi
Rash
Ulcers
Warts