

# 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.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Immunodeficiency Disease or HIV | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Heart Disease/Heart Attack     | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Stomach or Digestive Problems  | <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Respiratory/Breathing Problems | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Circulation Problems  |
| <input type="checkbox"/> Psychiatric Disorders          | <input type="checkbox"/> Ulcers                          | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Epilepsy/Seizures              | <input type="checkbox"/> Stroke                          | <input type="checkbox"/> TB                    |
| <input type="checkbox"/> Joint Replacement              | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Cholesterol Problems  |
| <input type="checkbox"/> Heart Valves or Pacemaker      | <input type="checkbox"/> Phlebitis                       | <input type="checkbox"/> 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)**

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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 \_\_\_\_\_