Welcome To Our Office

The confidential information below is important to our records and your health

Please Print

___Mr. Date_____
___Mrs.
___Miss

_____Age_____Birthdate_____
Last First Middle

___Single ___Married Spouse or
___Widowed ___Divorced Parent's Name_____

*SOCIAL SECURITY #*_____

Local Address_____ Phone _____

City_____ State_____ Zip _____

Permanent Address_____ Phone _____
(If different from above)

City_____ State_____ Zip _____

Occupation (Patient)_____ Employer _____

Business Address_____ Phone _____

Occupation (Spouse or Parent)_____ Employer_____

Business Address_____ Phone _____

Whom may we thank for referring you to our office? _____

FAMILY PHYSICIAN_____ LAST VISIT_____

FORMER PODIATRIST_____ LAST VISIT_____

Medications you are currently taking: USE ATTACHED FORM MARKED MEDICATION RECORD

Are you Pregnant?_____

INSURANCE: Primary Insurance _____ Secondary Insurance _____

Primary Insurance ID# _____ Secondary Insurance ID#_____

Signature_____

PATIENT MEDICAL HISTORY **PAGE 1**

NAME _____ **DATE** _____

Date of Birth _____ Age _____

Occupation _____ Primary Care Doctor _____

Explain Foot/Ankle problem ☐ Left ☐ Right Date Started _____

Pain ☐ Running ☐ Numbness ☐ Sharp ☐ Other _____

Any Treatment

Past Medical History -

☐ Bleeding Disorder ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Mitral Valve Prolapse

☐ Pacemaker ☐ A-Fib ☐ Congestive Heart Failure ☐ By Pass ☐ High Blood Pressure

☐ Lung Disorder ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Neurological Problems

☐ Stroke_____ ☐ Rheumatic Fever ☐ Thyroid Problems ☐ Kidney Problems ☐ Arthritis

Past Surgical History _____

Current Medication ☐ None _____

Family Medical History -

☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Stroke ☐ High Blood Pressure

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Personal History -

Smoker ☐ No ☐ Yes ☐ Never ☐ Quit Date ( ) **Alcohol** ☐ Yes ☐ No

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Allergies ☐ None ☐ Novocaine ☐ Marcaine ☐ Lidocaine ☐ Sulfa ☐ Aspirin

☐ Penicillin ☐ Mycin Antibiotic ☐ Codeine ☐ Tape ☐ Steroid ☐ Iodine

☐ Other (List Below)

_____

_____

Head , Neck , Eyes, Ear Problems -

□ None □ Vision Problem □ Glaucoma □ Dizziness □ Double Vision □ Headaches

□ Hearing Loss □ Sinus Infection □ Throat Pain □ Throat Infection □ Difficulty Swallowing

Respiratory Problems -

□ None □ Asthma □ Bronchitis □ Shortness of Breath □ Emphysema

Cardiovascular Problems -

□ None □ Chest Pain □ Congestive Heart Failure □ Murmurs □ High Blood Pressure

□ Swelling in Legs □ Leg Pain with Walking □ Stints □ Heart Surgery

Gastrointestinal Problems -

□ None □ Cirrhosis □ Hepatitis □ Liver Problems □ Stomach Ulcer

□ Diabetes □ Non Insulin □ Insulin □ Years Diabetic _____

□ Prostate Problem □ Thyroid Problem □ Pancreatitis □ Acid Reflex

Genitourinary Problems -

□ None □ Kidney Problems □ Weak Bladder □ Frequent Infection

Musculoskeletal Problems -

□ None □ Arthritis □ Osteoarthritis □ Rheumatoid Arthritis

□ Stroke □ Muscle Weakness (Location)

Dermatologic Problems -

□ None □ Skin Cancer □ Psoriasis □ Recurrent Infection

Neurological Problems -

□ None □ Seizures □ Fainting □ Tremors □ Neuropathy □ Spinal Problems

Allergies/Immunologic Problems -

□ None □ Allergy □ Lupus □ Autoimmune Disease

Signature _____ **Date** _____