



## Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Insurance Information

Insurance Company \_\_\_\_\_ Policy ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

### Primary Care Physician Info

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

Do you have any allergies to medications? \_\_\_\_\_

Do you take any medications? If yes, please list \_\_\_\_\_

What is your shoe size? \_\_\_\_\_ Weight? \_\_\_\_\_ Height? \_\_\_\_\_

Have you ever seen a podiatrist before?  Yes  No If Yes, Dr. \_\_\_\_\_

Why? \_\_\_\_\_

Whom can we thank for referring you? \_\_\_\_\_

Why are you here today? \_\_\_\_\_



## Medical History

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Medicines/Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves/Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Ankles or Feet	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tired Feet	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>			
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Surgeries you have had \_\_\_\_\_

Hospitalizations other than for the surgeries listed \_\_\_\_\_

Major illnesses \_\_\_\_\_

***I hereby consent and give my permission to the doctor to administer and perform such procedures upon me as the doctor deems necessary.***

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of patient, parent or guardian

\_\_\_\_\_  
Relationship to patient