Let's Get Acquainted

Please complete the following as fully as possible,
as this information will help us help you.

Patient's name: ____
Address: ____
City: ___________________________ State: ________ Zip code: ________
Phone #: ________________________ Date of birth: ___________________
Cell Phone#: _____________________ (To be used only if we can't reach you)
E-Mail address: ___________________________________
Marital status: S M W D Gender: M F Social Security #: ____________
Guardian if patient is a minor: _____________________________________
Guardian's address if different from above: ____________________________
Employer: ____
Occupation: ________________________ Work phone #: ________________
Business address: ____
Primary care physician: _____________________ Phone #: ________________
Date of last visit to your primary care physician: _________________

Insurance information

Primary insurance: _________________ Secondary insurance: ______________
Policy holders date of birth: ____________ Social security #: _______________
Spouse's insurance: ___________________ Spouse's date of birth: ____________
Spouse's or parent's employer: _______________________________________
Do you have prescription coverage (a drug plan)? Yes No Unsure

New patients are referred by other enthusiastic patients, and we would like to thank them…

Referred by: ____

Is there someone we can call if we cannot reach you regarding an appointment?
Name: ______________________________ Phone #: _____________________

Please complete the medical history section on the next page.

PATIENT MEDICAL HISTORY

Patient Name_________________________________ Date ____________

- Please describe the foot problem that brought you to the office today:
  ____
  ____
- Do you have or have ever had any of the following?

- ❑ Diabetes
- ❑ Abnormal blood pressure
- ❑ Heart condition
- ❑ Arthritis
- ❑ Kidney disease
- ❑ Liver disease/Hepatitis
- ❑ Thyroid disease
- ❑ Stomach ulcers / GERD / IBS
- ❑ Stroke
- ❑ Gout
- ❑ Anemia
- ❑ Bleeding disorders /Blood clots
- ❑ Difficulty healing
- ❑ Current pregnancy
- ❑ H.I.V. positive / AIDS
- ❑ Sexually transmitted disease
- ❑ Cancer
- ❑ Seizures / Epilepsy
- ❑ Asthma / Emphysema / TB
- ❑ Vascular disorders
- ❑ Neurological disorders / diseases
- ❑ Muscular disorders / diseases

- Please describe any other medical problems you have that are not mentioned above____
- Please describe any surgeries or hospitalizations within the last five years
  ____
- Are you currently taking any medication regularly? Please list prescription and non-prescription products ____________________________________
  ____
- I am allergic to or can not take:

- ❑ Penicillin
- ❑ Cortisone
- ❑ Codeine
- ❑ Shellfish
- ❑ Iodine
- ❑ Antibiotics
- ❑ Sulfa
- ❑ Aspirin
- ❑ Local anesthesia
- ❑ Tape
- ❑ Latex
- ❑ ____________

- Do you have any family history of Diabetes, Heart disease, Blood clots, Bleeding problems, Cancer, Strokes, Gout? If yes, which family member ________
- Smoking status (Circle): Current everyday, Current some days, Former, Never.
- Do you drink alcohol? Yes No If yes, how much? _________________
- Do you drink caffeinated beverages? Yes No If yes, how much? __________
- Does your work or lifestyle involve spending large amounts of time on your feet? Yes No If yes, please describe _____________________________
- Do you exercise? Yes No If yes, how often and how much ____________
- Height: ________ Weight: ________ Shoe size: __________

PATIENT NAME:___________________________ DATE: ___________

DEAR PATIENT: PLEASE CIRCLE ANY PROBLEMS YOU CURRENTLY ARE EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

CONSTITUTIONAL

decreased appetite faintness dizziness headache fever
difficulty breathing when lying flat feeling room spinning weakness
weight loss weight gain

CARDIOVASCULAR

chest or arm pain blood clots cramps in legs or feet when walking
cramps in legs or feet when sleeping high blood pressure
low blood pressure heart attack heart murmur heart palpitations
stroke varicose veins mitral valve prolapse

MUSCULOSKELETAL

joint ache or pain chronic neck pain chronic hip pain
chronic low back pain chronic ankle pain stiffness morning stiffness
weakness pain in feet in the morning pain upon rising anytime
swelling of joints limited motion in joints

INTEGUMENT

allergy to chemicals scarring dry skin itching skin cracking skin
thick or discolored toenails thick or discolored finger nails skin rash
scaring after surgery or injury skin cancer pain associated with skin

NEUROLOGICAL

tingling pins and needles numbness increased sensitivity to touch
burning decreased or lack of sensation to touch shooting pain
decreased or lack of sensation to heat or cold radiating pain

ENDOCRINE

increase or decrease in thirst increase or decrease in appetite
increase or decrease in urination weight loss or gain diabetes mellitus
thyroid problems post-menopause

HEMATOLOGICAL/LYMPHATIC

hemophilia anemia bruise easily blood transfusion reaction leukemia
sickle cell disease or trait weakness yellow discoloration of the skin

Patient signature ____

DPM Reviewed, sign & date_____________________________________