PATIENT HISTORY
_____

CURRENT DATE _____
UP-DATE _____

This information is required by your insurance company.

NAME _____ PHONE (_____)_____
S S # _____ ADDRESS _____
AGE _____ BIRTH DATE _____ CITY _____ STATE _____ ZIP_____
EMAIL _____
MARITAL STATUS: S M D W # CHILDREN _____ SHOE SIZE _____ SEX: M F RACE _____
HEIGHT _____ WEIGHT _____ B/P _____ PULSE _____

SPOUSE/ PARENT NAME _____ BIRTH DATE _____
SOCIAL SECURITY # _____

PATIENT'S OCCUPATION _____ EMPLOYER _____
WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____
WORK PHONE (_____)_____ EXT _____

PERSON RESPONSIBLE FOR PAYMENT _____
NAME OF MEDICAL INSURANCE _____ / _____

REFERRED BY _____ Friend Newspaper Phonebook
FORMER PODIATRIST _____
PRIMARY CARE PHYSICIAN _____ LOCATION _____
OTHER DOCTOR _____ SPECIALITY _____

DO YOU SMOKE?..... YES NO
ARE YOU DIABETIC? ..... YES NO If yes, year diagnosed _____
DO YOU HAVE ALLERGIES?..... YES NO If yes, please mark those you are allergic to and the reaction:

___ Penicillin	___ Sulfa	___ Tape
___ Aspirin	___ Motrin	___ Codeine
___ Novocaine	___ Demerol	___ Morphine
___ Cortisone	___ Iodine	___ Shrimp/Sea food

Other ALLERGIES: _____

MEDICAL PROBLEMS:	CURRENT MEDICATIONS:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OVER THE COUNTER MEDICATIONS/ VITAMINS:
_____
_____

WOMEN: Are you Pregnant? YES NO
Planning a pregnancy? YES NO

DO YOU HAVE A VASCULAR BY-PASS? YES NO Location: _____
DO YOU HAVE JOINT IMPLANTS? YES NO Location: _____
DO YOU HAVE REPLACEMENT HEART VALVES? YES NO

WHAT IS YOUR FOOT PROBLEM TODAY? _____

_____
DURATION OF PROBLEM _____ IF AN INJURY, DATE OCCURRED _____

PLEASE LIST ALL PAST SURGERIES YOU HAVE HAD:

PAST SURGERIES	YEAR	PAST SURGERIES	YEAR

PAST MEDICAL HISTORY--- CHECK ( ) THOSE YOU HAVE BEEN TREATED FOR...

_____ Diabetes
_____ High Cholesterol
_____ High Blood Pressure
_____ Heart Condition
_____ Chest Pain
_____ Heart Attack
_____ Stroke
_____ Poor Circulation
_____ Frequent Infections
_____ Liver Disease
_____ Hepatitis
_____ Kidney Disease
_____ Cancer
_____ Gout
_____ Rash/Skin Problems
_____ Arthritis
_____ Stomach Problems
_____ Stomach Ulcers
_____ Lung Disease
_____ Tuberculosis
_____ Asthma
_____ Urinary Problems
_____ Prostate Disease
_____ Bowel /Colon Problems
_____ Anemia
_____ Keloid/Thick Scar
_____ Allergies/Hay Fever
_____ Hearing Problems
_____ Rheumatic Fever
_____ Glaucoma
_____ Macular Degeneration
_____ HIV/AIDS

FAMILY HISTORY: Please mark if your family had any of these:

	Mom	Dad	Bro/ Sis
Heart Condition	_____	_____	_____
High Blood Pressure . . .	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Bleeding Disorder	_____	_____	_____
Kidney Disease	_____	_____	_____

SOCIAL HISTORY:

Check those you use ...
_____ Cigarettes How many packs/day? ___ If you quit, what year? _____
_____ Chewing Tobacco
_____ Cigars or Pipe
_____ Alcohol (beer, wine, mixed drinks) How much in an average week? _____
_____ Drugs (marijuana, cocaine, or others) How often? _____
_____ Coffee/tea Cups per day _____
_____ Pepsi/Coke/Soft drinks Cans per day _____

Type of regular exercise done: _____ Hours each week _____

PHARMACY _____ CITY _____

CONTACT PERSON _____ **PHONE** _____ hm wk

Spouse Relative _____ Friend