Your First Step to Healthy Feet

Patient Name: ____**Date of Birth**: ______________________

Address: _______________________________________**City** _______________ **State**: ________**Zip**:____________

Home Phone #: ______________________________**Cell Phone #:** ____

SS# __________________________________ **May we leave a message on your**: **O** home phone or **O** cell phone?

Email: ____

Are you : **O** Married **O** Single **O** Divorced **O** Widowed **Do you have children**?_________ If yes, how many?______

Primary Care Doctor: _____________________________________**Phone #:** _______________________

Employment Status: **O** Full Time **O** Part Time **O** Self Employed **O** Not Employed **Student**: **O** Yes **O** No

Employer Name: ____________________________________ **City**____

Name of Insurance: _______________________ **Insured Name**: ____

DOB: ______________ **Social Security #** _________________________ **Phone**:___________________________

Address if different from above: ____

In your own words, what is your foot problem? ____

____

Have you seen another doctor for this problem? **O** Yes **O** No

If Yes, what were the results? ____

____

____

Do you use tobacco products? **O** Yes **O** No

Do you drink alcohol? **O** Yes **O** No **How Much** ___________________

What size shoe do you wear? __________ **Height**__________ **Weight** __________

Family History:

Are your parents living? **O** Yes **O** No If no, who is deceased: ____

Please mark if your FATHER had: **O** diabetes **O** heart condition **O** high blood pressure **O** cancer **O** stroke
Please mark if your MOTHER had: **O** diabetes **O** heart condition **O** high blood pressure **O** cancer **O** stroke
Please mark if your brother/sister had: **O** diabetes **O** heart condition **O** high blood pressure **O** cancer **O** stroke

Medical History

____ Diabetes
____ High Blood Pressure
____ High cholesterol
____ Heart Condition
____ Stroke
____ Poor Circulation
____ Liver disease
____ Asthma
____ Lung Disease
____ Dementia/Alzheimer's
____ Hepatitis
____ Kidney Disease
____ Cancer – Type______________
____ Gout
____ Arthritis
____ Stomach problems
____ Stomach Ulcers
____ Tuberculosis
____ Hearing Problems
____ Thyroid Disease
____ Urinary Problems
____ Prostate Disease
____ Colon Problems
____ Anemia
____ Rheumatic Fever
____ Glaucoma
____ Macular Degeneration
____ HIV/AIDS
____ Allergies/Hay Fever

Current Medications: ____

____

____

Allergies: ____

Are You a Diabetic? **O** Yes **O** No If yes,What is your average blood glucose reading? ___________________________

Name of Doctor that manages your diabetic condition: ____

Are you being treated for an Arthritic condition? ___________ If Yes what type:_________________________________

Name of the Doctor treating this condition: ____

Surgical History:

Have you had any surgeries in the past 10 years? **O** Yes **O** No

If yes, please give dates & procedure:____

____

____

Emergency Contact: __________________________________ **Phone Number**: _____________________________

Relationship: ____________________________________

Pharmacy ____

HOW DID YOU HEAR ABOUT US? Doctor referral ☐ Insurance ☐ Friend/family ☐ Internet/Google ☐

Referred by: _______________________ Other:___________________________

Rev. 11/2020