

PLEASE PRINT

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F HEIGHT _____ WEIGHT _____ SHOE SIZE _____

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?
HOME PHONE #: (____) ____ - ____ YES NO WORK PHONE #: (____) ____ - ____ YES NO
CELL PHONE #: (____) ____ - ____ YES NO E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____ - ____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
___ YES ___ NO NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

EMPLOYED BY: _____ WORK PHONE: (____) ____ - ____ SOCIAL SECURITY NO: _____ - ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

USE OF TOBACCO: NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT - HOW LONG AGO? _____ TYPE _____
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
 STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS
 OTHER _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

PATIENT NAME: _____

MEDICAL HISTORY:

ALLERGIES

ANTIBIOTICS: PENICILLIN SULFA KEFLEX _____

PAIN MEDS: CODEINE MORPHINE ASPIRIN NSAIDS _____

OTHER: SHELLFISH IODINE ADHESIVE TAPE GENERAL / LOCAL ANES. _____

ILLNESSES: _____

PRIOR SURGERY:

HOSPITALIZATIONS/INJURIES: DATES? COMPLICATIONS?

SOCIAL HISTORY:

OCCUPATION: _____ **ACTIVITY LEVEL:** SEDENTARY / MOD. ACTIVE / ATHLETIC

MARITAL STATUS: S M D W **ALCOHOL:** TYPE _____ / DAY WK MO

TOBACCO: ___PKS/DAY X ___YRS. (IF QUIT, HOW LONG AGO? ___) **RECREATIONAL DRUG USE:** _____

REVIEW OF SYSTEMS:

MAJOR ILLNESSES: DIABETES YES OR NO - IF DIABETIC HOW LONG _____ IS IT WELL MAINTAINED? YES OR NO / ARTHRITIS - WHAT TYPE _____ / HEART DISEASE / HYPERTENSION / CHEST PAIN ANGINA / MI / CANCER / MITRAL VALVE PROLAPSE / MURMUR / ARRHYTHMIA / STROKE / CHF / PACEMAKER _____

RESPIRATORY: ASTHMA / BRONCHITIS / EMPHYSEMA / SINUS PROBLEMS / INFECTIONS / SHORTNESS OF BREATH / COPD / LUNG DISEASE OR BREATHING PROBLEMS / TUBERCULOSIS / SMOKER _____

EENT: SINUS PROBLEMS OR INFECTIONS / TONSILLITIS / THROAT INFECTIONS / GLAUCOMA / CATARACTS / EYE OR VISION PROBLEMS / HEADACHES / MIGRAINES / HEARING DEFICIT _____

GASTROINTESTINAL: ULCERS / REFLUX / HIATAL HERNIA / STOMACH DISORDER / BOWEL DISORDER / IRRITABLE BOWEL SYN. / HEMORRHOIDS / LIVER DISEASE _____

GENITO-URINARY: KIDNEY OR BLADDER INFECTIONS / KIDNEY STONES / PROSTATE / STD _____

VASCULAR DISEASE/BLOOD DISORDERS: POOR CIRCULATION / PVD / LEG OR CALF PAIN / NIGHT CRAMPS / REST PAIN / VEIN PROBLEMS / SWELLING / SPIDER VEINS / VARICOSE VEINS / PHLEBITIS / LEG ULCERS / BLOOD CLOTS / DVT / PE / BLEEDING OR CLOTTING DISORDERS / EASY BRUISING / ANEMIA / SICKLE CELL / TRANSFUSIONS / HEART ATTACK / HIGH BLOOD PRESSURE / LOW BLOOD PRESSURE /

OTHER: _____

ARTHRTIS: RHEUMATOID / OSTEO / GOUT / OTHER ARTHRITIS _____

SKIN DISORDERS: PSORIASIS / SKIN CANCER / OPEN WOUNDS _____

PSYCHOLOGICAL: ANXIETY / DEPRESSION / PSYCHIATRIC CONDITION / DRUG OR ALCOHOL DEPENDENCY / BIPOLAR /

MISC. ILLNESSES: EPILEPSY OR SEIZURES / THYROID DISEASE / MUSCLE DISEASE / FIBROMYALGIA / HEPATITIS / HIV OR AIDS / PREGNANCY - CHILDBIRTH / BACK TROUBLE / NEUROPATHY / POLIO / RHEUMATIC FEVER

OTHER: _____

PATIENTS NAME: _____

DOB: _____

Current problem(s) If you have more than one problem –please request additional sheet(s)

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW USING X'S.

LEFT FOOT



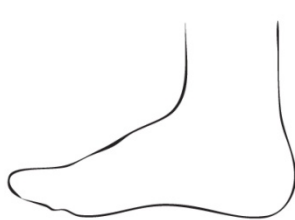
TOP OF FOOT



BOTTOM OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

DESCRIBE YOUR FOOT/ANKLE PROBLEM(S): _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING

RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES

RESTING DRESS SHOES HIGH HEELS WORSE AT NIGHT OR SLEEPING ANY CLOSED TOE SHOE

RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? YES / NO IF YES LIST PREVIOUS DR. AND TREATMENT: _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES NO (DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? YES NO