Patient Information Date: __________________

Name:__________________________/_____________________/______________________
Last First Middle

Mailing Address:
____
____
____
____

Cell Phone_________________________
Home Phone____________Work phone_________
Male____ Female____ Age___ Birthdate__/__/__
Place of Employment _______________________

E-main address:___________________

Marital Status ____ Spouses Name_____________________
Spouses Date of Birth __/__/____Spouses Employment __________ Work Phone _________
If Child, list parents or guardians name: ______________________________

Family Physician: _____________________________
Last visit to Family physician on date: ____/___/______
In case of emergency call ________________ phone number ________________

****

Please bring cards to receptionist for copying or fill out the following:

Insurance Information

Insurance Holders Name ____
Insurance Holders Birthdate _____/____/______ Insurance Holders Phone ___________
Insurance Holders Address
____
____
____

Name of Insurance Company _______________________
Address of Insurance Company _____________________
Policy Number ___________________________________
Group Number ___________________________________

Preferred Language ___________, Race please circle: African American, Asian, Caucasian, Hispanic, Other

Signature of Responsible Party ______________________________

Current Medical Conditions:
Do you have or have had any of the following:

	YES	NO
Anemia	___________	___________
Arthritis	___________	___________
Circulation Problems	___________	___________
Chronic Disease	___________	___________
Diabetes	___________	___________
Heart Condition	___________	___________
Hepatitis	___________	___________
Hypertension	___________	___________
Kidney Problems	___________	___________
Liver Problems	___________	___________
Rheumatic Fever	___________	___________
Ulcers	___________	___________
Are You Pregnant?	___________	___________

Family History:
Does any close relative have:
much__Have you ever
smoked__ when did you quit______
Heart Condition_____
much______
Arthritis____
List any Chronic or genetic disease ____

Social History:
Do you smoke now____If yes, how
Diabetes_____,Hypertension____
Do you drink____ If yes, how
Do you exercise________________
Sports Activities________________

Previous surgery and hospitalizations:
Please list all surgeries and hospitalizations please include reasons and dates :
____
____
____

Medications:
Please list all medications you are taking:
(Please include dosage)
____
____
____
____
____
Are you on Blood Thinners?_________

Allergies:
Codiene Yes_____ No ____
Keflex Yes_____ No _____
Penicillin Yes_____ No _____
Sulfa Yes_____ No _____
Local Anesthetics Yes_____ No _____
Other ______________________________
____

In your own words, please explain you chief problem with your feet:
____
____

I accept the ultimate responsibility for payments of fees to the doctor unless other written agreements have been made. I will allow doctor to file insurance claims. I further agree that the history given above is true.

Signature of Responsible Party: ____

Review of Health

Please circle any condition or disease that may apply to you:

Cardiovascular
Angina
Angioplasty
Heart Attack
Heart Murmur
Hypertension
Irregular Heart
Mitral Valve Prolapse
Open Heart Surgery
Pacemaker

Endocrine
Diabetes
Osteoporosis
Thyroid

Gastrointestinal
Cirrhosis
Diverticulitis
Gallbladder
Hepatitis
Irritable Bowel
Reflux Esophagitis
Ulcers

HEENT
Cataracts
Dentures
Glaucoma
Headaches
Hearing Loss
Nasal Polyps
Neck Stiffness
Sinus Problems
Tinnitus
Vertigo
Vision Problems

Immunological
Chronic Fatigue
Epstein Barr
HIV or AIDS
Weakened Immune

Musculoskeletal
Collagen Disease
Degenerative Arthritis
Fibromyalgia
Rheumatoid Arthritis

Neurological
Alzheimer's
Back Problems
Multiple Sclerosis
Parkinsonism
Scoliosis
Seizures
Stroke

Renal
Bladder Infections
Dialysis
Kidney Stones
Nephritis
Renal Failure
Transplant Kidney

Respiratory
Asthma
Breathing Problems
COPD
Emphysema
Chronic Lung
Infections
Pleurisy
Tuberculosis

Skin
Cellulites
Contact Dermatitis
Dry Scaly Patches
Fungal Nails
Infection Skin
Nevi
Rash
Ulcers
Warts