

WELCOME TO OUR OFFICE!

PLEASE PRINT

Name _____ Age _____ Male _____ Female _____
(First) (Last)

Home Address: _____ Apt. _____ City _____ Postal Code _____

Cell Phone _____ Business Phone _____ Home Phone _____

Email _____ Birth Date _____ Miss _____ Ms _____ Mrs _____ Mr _____ Dr _____
(Day Month Year)

Occupation _____ Family Physician _____

Physician's Phone Number _____ Date of last visit to Family Doctor _____

Medical Insurance (Extended Health Care)? No _____ Yes _____ Name of Insurance Company _____

If patient is a minor, name of person responsible for patient: _____
 _____ Relationship to Patient _____

My Foot problems involve my _____ Briefly describe your Current Foot Problems _____

_____ Left Foot _____

_____ Right Foot _____

_____ Both Feet _____

MEDICAL INFORMATION

1. How is your general health? Good Fair Poor
2. Are you subject to prolonged bleeding after tooth extractions or cuts? Yes No
3. Females - Are you Pregnant? Yes No
4. Have you ever been treated for any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in healing	<input type="checkbox"/>	<input type="checkbox"/>	Any heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>									
5. Are you subject to nervous disorders, fainting or dizziness? Yes No
6. Are you taking any medicine at the present time? Yes No
 If yes, please list _____
7. Have you been to a foot specialist before? Yes No
 If yes, please describe outcome _____
8. Have you had any previous foot surgery? Yes No
 If yes, please describe outcome _____
9. Have you ever worn custom made orthotics? Yes No
10. Are you allergic to any of the following? (Check if YES)

Penicillin <input type="checkbox"/>	Aspirin <input type="checkbox"/>	Cortisone <input type="checkbox"/>	Any Anesthetic <input type="checkbox"/>	Other <input type="checkbox"/> _____
Tape <input type="checkbox"/>	Codeine <input type="checkbox"/>	Any antibiotic <input type="checkbox"/>	Latex <input type="checkbox"/>	
11. Is there any other information about your health which we should know? Yes No

Who may we thank for referring you to this Office?

Name _____ Address _____

We appreciate your cooperation. THANK YOU.