WELCOME TO OUR OFFICE

Please print and complete the following information for your case history file

Last Name	First Name	Middle Initial		Today's Date
Spouse/Parent/Guardian's Name	Spouse's Birthday	Spouse's Employer	Patient DOB	Patient's Age
Residence Address	City	State	Zip	Marital Status Single Y Married Y Widowed Y Divorced Y
Home Phone	Patient's Social Security No.	Driver's License No.	Email Address	
Name of Employer & Address		Occupation	Business Phone	
Whom may we thank for referring you?		Address		
Name, address and phone of contact in case of emergency			Relationship	
If other than patient, name and address of person responsible for this account				

Do you have Medical Insurance	Carrier Name	Subscriber Name	Policy No.	Group No.
Y Yes Y No				
Is it through your employer	**Is there secondary insurance?**	**Carrier Name**	**Subscriber Name**	**Policy No.**
Y Yes Y No	Y Yes Y No			

List any medical conditions you have (allergies, impairments, etc.)		
Name of family physician	Phone	Are you currently under Y Yes Your physician's care Y No
If yes, for what	May we contact your physician Y Yes For your health records Y No	

Have you had previous Treatment by a podiatrist	When	For What
Y Yes Y No		
My chief foot complaint is:		

My condition(s) have existed for:	Days	Weeks	Months	Years
What medicines do you take regularly:				

Do you have or have you had any of the following: (*do not know)

	Yes	No	DNK		Yes	No	DNK		Yes	No	DNK
Foot or leg injuries	Y	Y	Y	Diabetes	Y	Y	Y	Anemia	Y	Y	Y
Foot or leg surgery	Y	Y	Y	Heart trouble	Y	Y	Y	Gout	Y	Y	Y
Foot or leg cramps	Y	Y	Y	Epilepsy	Y	Y	Y	Fainting spells	Y	Y	Y
Foot or leg numbness	Y	Y	Y	Liver Disease	Y	Y	Y	Bleeder	Y	Y	Y
Knee pain	Y	Y	Y	Kidney disease	Y	Y	Y	Blood disease	Y	Y	Y
Unequal leg length	Y	Y	Y	Rheumatic fever	Y	Y	Y	Circulation problems	Y	Y	Y
Weak Ankles	Y	Y	Y	High blood pressure	Y	Y	Y	Hardening of arteries	Y	Y	Y
Bunions	Y	Y	Y	Polio	Y	Y	Y	Varicose veins	Y	Y	Y
Foot skin problems	Y	Y	Y	Bursitis	Y	Y	Y	Arthritis	Y	Y	Y
Toe nail problems	Y	Y	Y	Stomach ulcers	Y	Y	Y	Cancer	Y	Y	Y
Low back pain	Y	Y	Y	Asthma	Y	Y	Y	Prone to infection	Y	Y	Y

Are you allergic or sensitive to:

	Yes	No	DNK
Novocain	Y	Y	Y
Penicillin	Y	Y	Y
Adhesive tape	Y	Y	Y
Materials	Y	Y	Y
Drugs	Y	Y	Y
Foods	Y	Y	Y
Other describe	Y	Y	Y
_____			
_____			
_____			
_____			

I hereby give Dr. _____ permission to examine and treat my feet.

_____ _____

Patient, Parent, or Guardian's Signature Date