

Patient History Form

Please fill out the following confidential form for our records.

Patient name: _____ Age: _____ Height: _____ Weight: _____ Shoe size: _____

Current foot or ankle problem: _____

When did the problem start? _____

What has been done to treat the problem? _____

Are you or have you been under a physician's care in the past two years? Yes _____ No _____

If yes, please explain: _____

Name of family physician: _____ Date last seen: _____

Name of former podiatrist: _____ Date last seen: _____

What conditions were you treated for: _____

MEDICAL HISTORY

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Vascular/circulatory disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Accident/injuries | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney or bladder | <input type="checkbox"/> Immune disease (HIV, AIDS) | <input type="checkbox"/> Foot problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding disorders (sickle cell) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke or heart attack | <input type="checkbox"/> Anemia/blood | <input type="checkbox"/> Epilepsy/seizures | _____ |
| <input type="checkbox"/> Stomach ulcer/reflux | <input type="checkbox"/> Asthma/bronchitis | <input type="checkbox"/> Depression or anxiety | _____ |

Please explain any positive responses from above information: _____

MEDICATIONS (please include dosage of each)

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

ALLERGIES: (penicillin, novocaine, tape, foods, etc.)

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

SURGERIES and HOSPITALIZATIONS: (describe procedure, year and any complications)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

SOCIAL HISTORY

Occupation: _____ Tobacco: If yes, how much? _____

Alcohol: If yes, how much? _____ Illicit drugs: If yes, how much? _____

FAMILY HISTORY (diabetes, heart disease, gout, cancer, foot problems or other): _____

★ Whom may we thank for referring you to our office? _____

I hereby give Foot Care Center permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

Signature: _____ Date: _____

Acknowledgement of receipt of notice of privacy practices

I acknowledge that I was provided a copy of the notice of Privacy, and that I have read (or had the opportunity to read if I so choose) and understand the notice

Print Name

Date

Parent or authorized signature

Patient Signature

Disclaimer

Your insurance coverage will be verified. This is quote of your medical benefits. Payment is not guaranteed until the claim is submitted and reviewed. In the event your insurance denies payment, you are responsible for the balance in full. At the time of your visit, you are responsible for the co-payment where applicable and/or percentage and/or deductible (if not satisfied this year), according to information obtained from your insurance company.

Signature

Date