Account Number _____: **SARASOTA FOOT CARE CENTER, PA**

Name_____ Birthdate_____ Date_____

Height_____ Weight_____ Shoe size_____

Reason for visit_____

_____

_____

Whom may we thank for referring you to our office?_____ Date of onset_____

Medical Doctor _____ Date last seen_____ Former Podiatrist_____

Medical History (check only those items that apply)

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disease
- ❑ Blood disease
- ❑ Cancer
- ❑ Charcot joint
- ❑ CVA (stroke)
- ❑ Depression
- ❑ Diabetes diet/oral/insulin ___yr
- ❑ Epilepsy
- ❑ Eye pathology
- ❑ Gastric reflux
- ❑ GI Ulcers
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Kidney disease
- ❑ Leg cramps/numbness
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Peripheral vascular dis
- ❑ Rheumatic fever
- ❑ Varicose veins
- ❑ Osteoporosis

Other Medical problems (please list)_____

_____

Surgical History (check only those items that apply)

- ❑ Angioplasty
- ❑ Appendectomy
- ❑ Arterial by-pass
- ❑ Back surgery
- ❑ Breast biopsy
- ❑ Carotid artery sx
- ❑ Cataract
- ❑ Colonoscopy
- ❑ C-section
- ❑ D and C
- ❑ Endoscopy
- ❑ Foot surgery
- ❑ Gall bladder sx
- ❑ Heart by-pass
- ❑ Heart catheter
- ❑ Hernia repair
- ❑ Hip replacement
- ❑ Hysterectomy
- ❑ Kidney removal
- ❑ Kidney stone sx
- ❑ Knee replacement
- ❑ Mastectomy
- ❑ Neck surgery
- ❑ Open heart sx
- ❑ Pacemaker
- ❑ Prostate surgery
- ❑ Tonsillectomy
- ❑ Venous ligation
- _____

Other Surgery (please list)_____

_____

_____

Medications (please list)_____

_____

_____

Family History (please circle if positive)	Diabetes	Heart disease	Cancer	High blood pressure
Mother	yes	yes	yes	yes
Father	yes	yes	yes	yes
Siblings	yes	yes	yes	yes

Current Activities and Social History (please check)

- ❑ Alcohol (frequency)_____ Tobacco _____ppd Date quit_____ Caffeine (type)_____
- ❑ PhysicalActivities_____

Allergies (please check)

- ❑ Novocaine
- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Cortisone
- ❑ Adhesive tape
- ❑ Sulfa
- ❑ Other_____

Review of systems (filled out by nurse) **Mental status** alert and oriented / alert but not oriented / confused / lethargic

Head Eyes	dizziness / syncope / headaches / double vision / infection / total blindness
Ears Nose Throat	dysphagia / hoarseness / hearing loss / infection / tinnitus / epistaxis / otalgia / sores
Respiratory	asthma / bronchitis / dyspnea / orthopnea / hemoptesis / emphysema
Cardiovascular	hypertension / murmurs / chest pain / edema / claudication / ulceration / phlebitis / heart attack
Gastrointestinal	jaundice / cirrhosis / hepatitis / abnormal stool / GI ulcer / nausea / vomiting
Genitourinary	dysuria / polyuria / hematuria / pyuria / nocturia / renal dialysis / incontinence / urinary infection
Musculoskeletal	joint pain / joint swelling / muscle pain / poststatic dyskinesia / weakness / back pain
Dermatologic	rash / bleeding / bruising / pruritis / hypertrophic nails / ulcer / skin infection / psoriasis
Neurologic	paralysis / stroke / tics / tremors / seizures / tingling / numbness
Allergic/immunologic	allergies / anaphylactic reactions / HIV / immunosuppressed / recurring infections **Tech**_____

Sarasota Foot Care Center, PA

Please print clearly

Account Number _____

Name _____
(Last) (First) (Middle)

Local Address _____

_____
City State Zip

Northern Address _____

_____
City State Zip

Local Phone _____ **Cell Phone** _____ **Northern Phone** _____

Date of Birth _____ **Age** _____ **Gender:** ☐ Female ☐ Male **Social Security #** _____

Email Address _____

Race:	Ethnicity:	Smoking:	Marital Status:	Language:	Employment:	Student:
☐ Caucasian	☐ nonHispan	☐ Daily	☐ S	☐ English	☐ Full time	☐ Full time
☐ Black	☐ Hispanic	☐ Some days	☐ M	☐ Spanish	☐ Part time	☐ Part time
☐ Asian		☐ Former	☐ D	☐ Other		
		☐ Never	☐ W			

Occupation _____ **Employer** _____ **Phone** _____

Work address _____

Next of Kin _____ **Phone #** _____

Responsible party (for minor) _____ **Relationship** _____
(Last) (First)

Their employer _____ **Occupation** _____ **Phone** _____

Primary Insurance _____ **Secondary Insurance** _____

Name of policy holder _____ **DOB** _____ **SS#** _____

Is Insurance through employer? ____ Yes ____ No **Yours or Spouse?** _____

Pharmacy _____ **Location** _____ **Phone #** _____

IF WE CANNOT VERIFY YOUR INSURANCE BENEFITS BEFORE YOU ARE SEEN, YOU WILL BE ASKED FOR PAYMENT IN FULL

IF THIS VISIT IS RELATED TO A WORK INJURY, AUTO ACCIDENT, OR INVOLVES ANY TYPE OF LIGITATION, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

I hereby authorize the release of any medical information necessary for processing claims and payment of medical benefits to myself or the party who accepts assignment (lifetime signature). **I understand that, as the patient receiving medical treatment, I am responsible for payment regardless of insurance coverage or litigation.**

Patient Signature _____ **Date** _____
(Responsible party)

(over)