WELCOME TO OUR OFFICE

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

TODAY'S DATE: _____ Social Security Number: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

Date of Birth: _____ Age: _____ Name of Spouse: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Driver's License: _____

Name of Employer: _____ Occupation: _____

Who may we thank for referring you? _____

Name of emergency contact: _____ Relationship: _____

Phone number of emergency contact: _____

Name of Family Physician: _____ Phone: _____

May we contact your physician for your health records? _____ Yes _____ No

Have you had previous treatment by a Podiatrist? _____ Yes _____ No

I hereby give Professional Foot and Ankle Center permission to examine and treat my feet.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

HEALTH QUESTIONAIRE

DATE:_____

NAME: _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____

My chief foot complaint is:_____

This condition has existed for: _____ Days _____ Weeks _____ Months _____ Years

Do you have or have you had any of the following:

	Y	N		Y	N		Y	N
Anemia			Foot or Leg Injury			Kidney Disease		
Asthma/COPD			Foot or Leg Numbness			Liver Disease		
Back Problems			Foot or Leg Surgery			Polio		
Bleeding Disorders			Gout			Rheumatoid Arthritis		
Cancer			Heart Disease			Stomach Ulcer		
Circulation Problems			Hepatitis			Stroke		
Diabetes			HIV/AIDS			Thyroid Disease		
Epilepsy/Seizure			High Blood Pressure			Other:		
Foot or Leg Cramps			High Cholesterol					

Surgical History:

_____

_____

Family History:

Mother? Father?	Y	N	Mother? Father?	Y	N
Cancer			High Blood Pressure		
Diabetes			Gout		
Heart Disease			Rheumatoid Arthritis		
High Cholesterol			Stroke		

Do you currently smoke: ___ Yes ___ No Did you ever smoke: ___ Yes ___ No

Do you drink alcohol: ___ Yes ___ No Do you use illegal drugs: ___ Yes ___ No

What medications do you take (dosage/directions): _____

_____

_____

Allergies: _____