T. Todd Horak, DPM, PC
Julia E. Shauger, DPM, PC

Patient's Name _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Tel # _____ E-mail _____ Gender M F Marital Status ___

Name of Spouse _____ Date of Birth _____ SSN _____

Parent's Name (if minor) _____ Date of Birth _____ SSN _____

What is your FOOT or ANKLE problem_____ How long _____ How much pain (0-10) _____

What type of symptoms: sharp shooting burning achy tingling/numb difficult to walk (circle all that apply)

Does your employment require prolonged standing, walking or lifting _____ Is light duty available _____

What relieves your symptoms _____ Do you have: nausea fever chills (circle all that apply)

What type of treatments are you expecting _____ What other treatments have been tried _____

Other health problems (diabetes, high blood press, asthma, etc) _____ Medications _____

Activities/Lifestyle _____ Smoker/Nicotine use _____ Alcohol _____ Street Drugs _____

Parents healthy? _____ Any drug allergies _____ Height _____ Weight_____ Shoe Size _____

List recent hospitalizations or surgeries _____

Emergency contact person _____ Tel # _____

Name of family doctor _____ Address _____

How did you hear about us _____

Employer (self) _____ Tel # _____

Employer (spouse) _____ Tel # _____

Do you have medical insurance _____ Name of Carrier _____

Insured's name _____ Date of Birth _____ SSN _____

Policy/Group # _____ ID # _____

I hereby request and authorize Dr. T. Todd Horak, DPM, Dr. Julia E. Shauger, DPM, and whomever they may designate as an assistant to perform such procedures as they may deem necessary in the diagnosis and/or treatment of my foot or ankle condition. I further certify that to the best of my knowledge and belief, the information provided in the above personal health history is true and accurate. I hereby authorize payment directly to either Dr. T. Todd Horak or Dr. Julia E. Shauger for services rendered by themselves or their staff and accept full responsibility for resolving any outstanding balance.

_____ _____ _____

Patient's signature Guardian's signature (if patient is a minor) Date