

**DR. JEFFREY KLEIS DPM**  
**PATIENT INFORMATION FORM**  
(PLEASE PRINT)

DATE: \_\_\_/\_\_\_/\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ SEX: M F  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ YES NO

WORK PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ YES NO

CELL PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ YES NO

E-MAIL: \_\_\_\_\_ YES NO

PRIMARY LANGUAGE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ WHO REFERRED YOU TO US? \_\_\_\_\_

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

\_\_\_ YES NAME(S) \_\_\_\_\_

\_\_\_ No

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

**YOUR MEDICAL HISTORY**

ALLERGIES:  NONE KNOWN  MEDICATIONS \_\_\_\_\_

ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_

TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

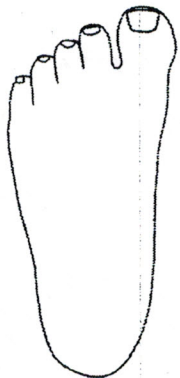
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS: _____								

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

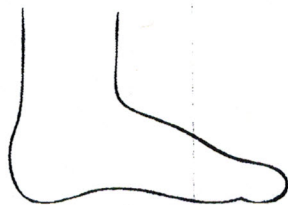
**LEFT FOOT**



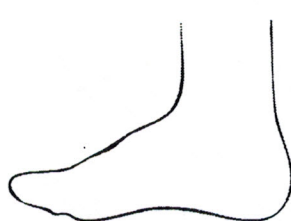
TOP OF FOOT



BOTTOM OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT

**RIGHT FOOT**



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE  
 STROKE  CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS  
 OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

HEEL PAIN	Y	N	BALL OF THE FOOT PAIN	Y	N
ARCH PAIN	Y	N	PAIN/DIFFICULTY WALKING	Y	N
ANKLE PAIN	Y	N	SKIN PROBLEMS (FEET)	Y	N
NAIL DISCOLORATION	Y	N	OTHER FOOT PROBLEMS	Y	N

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

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TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

\_\_\_\_\_  
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE