THE FOOT DOCTORS
ADVANCED FOOT & ANKLE CARE
....with our gentle touch

Nicole M. Surdock, D.P.M
Mark Brenis, D.P.M
Alvie Hurray, D.P.M

Patient Information

Today's Date:		Primary Doctor:	
Last Name:	First Name:	Middle Name:	
Date of Birth:	Sex:	Marital Status:	Email Address:
Social Security Number:	Home Phone Number:	Cell Phone Number:	
Home address (street, city, state, zip code):			
Employer:	Occupation:	Employer Phone Number:	
Referred to clinic by:			

If patient is a minor, please fill out the information for parent/guardian below:

Parent/Guardian Name:_____ DOB: _____

Relationship to patient: _____ SSN: _____

Parent/Guardian Employer:_____ Occupation: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Insurance Information

Please give your insurance card & ID to the receptionist

In Case of Emergency

Name of local contact:	Relationship:	Home phone number:	Alternate phone number:

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Past Medical History

Circle 'Yes' or 'No' to indicate if you currently have or have had any of the following:

AIDS/HIV	Yes	No		Circulation problems	Yes	No		Stomach ulcers	Yes	No
Arthritis (Rheumatoid)	Yes	No		Diabetes Type I	Yes	No		Kidney problems	Yes	No
Anemia	Yes	No		Diabetes Type II	Yes	No		Liver disease	Yes	No
Angina (Chest pain)	Yes	No		Epilepsy	Yes	No		Low blood pressure	Yes	No
Artificial heart valve	Yes	No		Eye Problems	Yes	No		Neuropathy	Yes	No
Asthma	Yes	No		Fainting	Yes	No		Psychiatric care	Yes	No
Back problems	Yes	No		Gout	Yes	No		Radiation treatment	Yes	No
Bleeding disorder/clot	Yes	No		Headaches	Yes	No		Respiratory disease	Yes	No
Cancer (specify)	Yes	No		Heart Disease	Yes	No		Shortness of breath	Yes	No
Chemical dependency	Yes	No		Hemophilia	Yes	No		Stroke	Yes	No
Chronic diarrhea	Yes	No		Hepatitis (Type:__)	Yes	No		Tuberculosis	Yes	No
Sexually Transmitted Disease (specify)	Yes	No		High blood pressure	Yes	No		Other (Specify)		

Past Surgeries

List any surgeries you have had (Include location of surgery and date performed): _____

_____

_____

Allergies

Adhesive Tape: Yes No	Anticoagulants: Yes No	Aspirin: Yes No	Codeine: Yes No	Iodine: Yes No	Sulfa: Yes No	Local Anesthetic: Yes No
Penicillin: Yes No	Other medications (please specify):					

Medication/Substance Use

Tobacco Use (packs/day): _____ # of years: _____ If former smoker, quit date: _____

Alcohol Use (# of drinks/week): _____ Recreational drug use:_____

List Medications you take with dosage and frequency. If you brought a list, please provide it to the medical assistant

Pharmacy Information

Preferred Pharmacy Name: _____ City: _____