

PATIENT INFORMATION SHEET

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

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE#:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CELL PHONE#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SEX: M F BIRTHDATE: \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ OTHER \_\_\_\_\_

EMPLOYED? Y\_\_ N\_\_ FULL-TIME STUDENT? Y\_\_N\_\_ PART-TIME STUDENT? Y\_\_N\_\_

WHO IS RESPONSIBLE FOR PATIENT BILL(FILL IN ONLY IF OTHER THAN PATIENT)

SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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EMPLOYER: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT: \_\_\_\_\_

WHO REFERRED YOU TO US? \_\_\_\_\_

PRIMARY INSURANCE INFORMATION: INSURANCE COMPANY: \_\_\_\_\_

POLICY NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SUBSCRIBER (IF OTHER THAN PATIENT): SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SEX: M F BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_

SECONDARY INSURANCE INFORMATION: INSURANCE COMPANY: \_\_\_\_\_

POLICY NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SUBSCRIBER (IF OTHER THAN PATIENT): SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME/MI: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SEX: M F BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_

PATIENT'S MEDICAL INFORMATION

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

1. Please describe your foot problem: \_\_\_\_\_

2. Females: Is there a chance that you might be pregnant? \_\_\_ Yes \_\_\_ No  
Do you take birth control pills? \_\_\_ Yes \_\_\_ No

3. Are you allergic to any medication? \_\_\_ No \_\_\_ Yes, Which? \_\_\_\_\_

4. Are you presently taking any medications? \_\_\_ No \_\_\_ Yes, Please List \_\_\_\_\_

5. Do you have or have you had any of the following medical problems?

**\*\*CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU\*\***

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Poor Healing         |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Gout                | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Murmurs       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Back Problems      | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Scarring Problems    |
| <input type="checkbox"/> Bleeding Problems  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Bowel Problems     | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Liver Problems      | <input type="checkbox"/> Urinary Problems     |
| <input type="checkbox"/> Burning Feet       | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Ulcers in Feet       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Numbness in Feet    | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Open Heart Surgery  | <input type="checkbox"/> Leg Cramps           |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Retinopathy          |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Nephropathy          |

6. Do you have any medical problem not listed above? \_\_\_ Yes \_\_\_ No  
If so, Please list: \_\_\_\_\_

7. Have you ever had an operation or surgery? \_\_\_ Yes \_\_\_ No  
Surgeries you've had: \_\_\_\_\_  
Any surgical complications? Please list \_\_\_\_\_

8. Do you have a family history of:  
\_\_\_ Diabetes \_\_\_ Poor Circulation \_\_\_ Heart problems \_\_\_ Bunions

9. Do you smoke? \_\_\_ Yes \_\_\_ No If yes, how many packs/day \_\_\_\_\_

10. Do you drink alcohol? \_\_\_ more than 2/day? \_\_\_\_\_

11. Have you ever had a broken bone or fracture? \_\_\_ Yes \_\_\_ No

12. Who is your Internist/Family Doctor? \_\_\_\_\_ Last seen when? \_\_\_\_\_

13. What is your ... Age? \_\_\_\_\_ Weight? \_\_\_\_\_ Shoe Size? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_