

Welcome to Friendly Foot Care

Please Provide the Following Important Medical Information to the Best of Your Ability

Patient Name: _____ Date: _____

Do you have any allergies? YES NO (circle) If YES, list all allergies: _____

If you are female, are you nursing currently or could you be pregnant? YES NO (circle)

Past Medical History:

1. Please check the "Yes" or "No" box if you have any of the following illnesses; for "Yes" answers, please explain.

	YES	NO	EXPLAIN HERE		YES	NO	EXPLAIN HERE
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach/Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prior Ankle Sprains	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Blood Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____				

2. Please list any operations (and dates) that you have ever had: _____

3. Are you taking any medications or vitamins? YES NO (circle) If YES, list all current medications (and amounts, times per day): include aspirin, vitamins, herbal supplements, antacids, birth control, creams, ointments):

Social History:

Height? _____ Weight? _____ (circle) Are you underweight obese overweight correct weight or unsure?

Do you smoke? **YES NO**
 If "yes", how much? _____

If no, did you smoke previously? If "yes", when did you quit? _____

Do you do any illegal drugs? If "yes", list them. _____

How often do you drink alcohol? _____

What is your occupation? _____

How would you describe your mood (i.e. happy, calm, anxious etc.)? _____

Family History:

1. Please check the "Yes" or "No" box if any relatives have any of the following illnesses/problems:

	YES	NO	RELATIVE		YES	NO	RELATIVE
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heel spurs/heel pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bunions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flatfeet	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Blood Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other Foot/Ankle Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Patient Name: _____ Date: _____

Review of Systems: 1. Please check the "Yes" or "No" box if you have any of the following symptoms.
 2. Please check the "Current box" if you are currently experiencing this symptom.

		<u>YES NO CURRENT</u>					<u>YES NO CURRENT</u>		
General	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	Eye Pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Weight Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eye Redness/Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Daytime Sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<hr/>			
	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ears/Nose/Throat			
Allergy	Environmental Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sneezing Fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neuro	Any Numbness/Tingling in feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Numbness/Tingling elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Any Burning in feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Burning elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>				
	Shooting Pain in Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory				
	Shooting Pain Elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Leg Cramps when walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>				
	Leg Cramps in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hematological/Lymphatic				
	Swelling of feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal					Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>				
	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine				
	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feels Warmer Than Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Black or Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feels Colder Than Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wakes Often to Urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Any Open Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>				
	Warts on feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary				
	Warts Elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Other Lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Fungal Toe Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Fungal Fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Groin Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>				
	Abnormal Moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle-Skeletal				
Psych	Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Other Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Easily Loses Temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Drug/Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any Limited Joint Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Family Physician: _____ Last Visit Date: _____

Family Physician Address: _____

Cardiologist: _____ Last Visit Date: _____

Neurologist: _____ Last Visit Date: _____

List other foot/ankle doctors seen: _____

Name of person filling this out, if not the patient: _____

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Cellular: (____) _____ Work: (____) _____

Email address: _____

Patient's SSN: _____ - _____ - _____ Patient's Birthday: ____/____/____

Marital Status (circle one): Single Married Divorced Separated Widow Partner Child

Are you currently residing in a nursing home? Y N If yes, which one? _____

In Case Of Emergency, Notify (please provide two names):

1. _____ Phone: (____) _____

2. _____ Phone: (____) _____

Employer _____ Phone: (____) _____

Employer Address: _____ City, ST, Zip _____

How did you hear of us? (Circle one): Internet Newspaper Yellow Pages Doctor Patient

Please indicate which Newspaper ad/patient/doctor? _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Self Spouse Parent

ID # _____ Group #: _____ Plan: _____

Insured's Name: _____

(THE PERSON'S NAME ON THE INSURANCE CARD AS THE SUBSCRIBER)

Insured's SSN: _____ - _____ - _____ Insured's Birthday: ____/____/____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Employer _____ Phone: (____) _____

Secondary Insurance Carrier: _____ Self Spouse Parent

ID # _____ Group #: _____ Plan: _____

Spouse's Name: _____ Spouse's Birthday: ____/____/____

Spouse's SSN: _____ - _____ - _____

I attest that I have provided accurate health insurance information for coverage or benefits for medical care. Also, I have no other medical insurance other than what I have listed above. I authorize payment of medical benefits to my physician for services rendered.

DATE _____

(Signature of insured or authorized person)