

Welcome to Friendly Foot Care

(Please complete to the best of your ability)

Today's Date: _____ Patient Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Patient's SSN: (required) _____ - _____ - _____ Patient's Birth Date: ____/____/____

Patient's Email address: _____

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

Spouse's Name: _____ Spouse's Birth date: ____/____/____

Spouse's SSN: _____ - _____ - _____ Spouse's Phone (cell): (____) _____

What contact method do you prefer our office use to contact you? Telephone? H C W or/both Email? Y N
If we contact you by telephone, is it ok to leave a message? Y N

Patient's Employer _____ Phone: (____) _____

Employer Address: _____ City, ST, Zip _____

Spouse's Employer _____ Phone: (____) _____

Spouse's Employer Address: _____ City, ST, Zip _____

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

In Case Of Emergency, Notify: _____ Phone: (____) _____

Race (circle): American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Black/African American
White Hispanic Other

Ethnicity (circle): Hispanic/Latin Not Hispanic/Latin Language (circle): English Indian Spanish Russian Other

How did you hear about our office? (Circle) Post-Tribune NWI Times Internet Facebook Doctor

Yellow Pages Patient Insurance Please be specific _____

Insurance Information

Primary Ins. Carrier: _____ Self Spouse Parent

ID # _____ Group #: _____ Plan: _____

Insured's Name: _____ Insured's Birth date: ____/____/____

Insured's SSN: _____ - _____ - _____ Insured's Home Phone: (____) _____

Insured's Address: _____ City/State/Zip _____

Insured's Employer _____ Phone: (____) _____

Secondary Ins. Carrier: _____ Self Spouse Parent

ID # _____ Group #: _____ Plan: _____

Insured's Name: _____ Insured's Birth date: ____/____/____

Insured's SSN: _____ - _____ - _____ Patient Signature: _____

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

Patient Name: _____ Date: _____

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

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

Past Medical History:

1. Please check the "Yes"/"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"/>	_____
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____				

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

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, and ointments): _____

4. Which pharmacy do you use? (Include address, city, state and telephone number)

PLEASE NOTE - PRESCRIPTIONS WILL BE SENT TO YOUR PHARMACY ELECTRONICALLY BY THE END OF THE DAY

5. Do you permit us to obtain your prescription history from your pharmacy? (circle) Yes No

6. Primary Care Physician (name and phone number) _____

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? _____

Is today's visit a result of an accident or injury? Y N If yes, is it work related? Y N If yes, please provide your Workers Comp information. If it is an accident or injury, is it part of a liability case? Y N

Family History:

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"/>	_____	Blood Clot	<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"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____				