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Patient Information

Patient's Name_____ Telephone_____

Home Address_____ _____City_____State_____Zip_____

Date of Birth_____Age_____Social Security #_____-_____-_____Driver's License #_____

Sex: M / F Marital Status: S M D Sep W Full Time Student _____Yes _____No

Patient employed by_____Occupation_____

Business Address_____ Business Phone_____

Spouse / Relative _____Employed by_____

Business Address_____ Business Phone_____

Who referred you to this office? Name_____Address_____

What pharmacy do you use? _____

Guarantor Insurance Information

Company or Program Insured SS# / ID# Group # Date of Birth (**insured**)

1. _____

2. _____

Authorizations

❑ Yes ❑ No I hereby authorize benefits directly to the physician for surgical and/or medical benefits

❑ Yes ❑ No I also understand I am responsible for any portion of my bill not covered by the insurance company

❑ Yes ❑ No I hereby authorize release of information for insurance claim purposes.

❑ Yes ❑ No The information authorized for release may include information which may be considered a communicable or
venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS

I certify that the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

_____ _____ _____
Signature of Responsible Party if other than patient Date Signature of Patient

Physician_____ City_____Last visit_____

Physician_____ City_____Last visit_____

Are you now, or have you been under a physician's care during the past 2 years? ❑ Yes ❑ No

Date of last complete physical examination: _____

ARE YOU UNDER ACTIVE CARE FOR DIABETES? ❑ Yes ❑ No **CIRCULATION PROBLEMS**? ❑ Yes ❑ No
IF SO, DOCTOR'S NAME_____ LAST SEEN_____
INSULIN DEPENDENT DIABETIC? ❑ Yes ❑ No DIET CONTROLLED? ❑ Yes ❑ No
YEARS BEING DIABETIC_____ AVERAGE BLOOD SUGAR RANGE_____

REVIEW OF SYSTEMS (Check each item that applies to you)

CONSTITUTIONAL (GENERAL):

❑ Weight loss/over 10 lbs. ❑ Weight gain/over 15 lbs. ❑ Fever ❑ Chills
❑ Fatigue ❑ Nausea ❑ Other_____

EYES, EARS, NOSE, & THROAT:

❑ Impaired sight ❑ Eye disease ❑ Eye pain ❑ Vision problem
❑ Eye infections-frequent ❑ Glaucoma ❑ Hearing loss ❑ Ringing in ears
❑ Ear infections ❑ Dizzy spells ❑ Fainting spells ❑ Nose bleeds-frequent
❑ Breathing difficulty ❑ Sinus problems ❑ Sore throat ❑ Hoarseness
❑ Speech difficulties ❑ Dental problems ❑ Abscessed (infected) teeth
❑ Other_____

RESPIRATORY:

❑ Pneumonia/Pleurisy ❑ Bronchitis/Chronic cough ❑ Asthma/Wheezing ❑ Shortness of breath
❑ Tuberculosis ❑ Emphysema ❑ Hay fever/Allergies ❑ Limited Exercise Tolerance
❑ Use oxygen at home ❑ C.O.P.D. ❑ History of Smoking ❑ Other_____

CARDIOVASCULAR:

❑ Chest pain ❑ Heart attack ❑ High blood pressure ❑ Open-heart surgery
❑ Heart murmur ❑ Chronic Swelling ankles/feet ❑ Palpitations ❑ Irregular beat/pulse
❑ Pacemaker ❑ Mitral valve prolapse ❑ Angioplasty ❑ Artificial heart valve
❑ Rheumatic fever ❑ Circulation disorder ❑ High cholesterol ❑ Leg pain/walking
❑ Leg pain/at rest ❑ Tiredness in legs ❑ Varicose vein ❑ Phlebitis
❑ Blocked arteries ❑ Cold, numb feet ❑ Angina ❑ Congestive Heart Failure
❑ Angina - Increased Intensity ❑ Angina - New Onset at rest ❑ Change in chest pain pattern
❑ Cardiac Occlusive Disease ❑ Stroke ❑ Other_____

GASTROINTESTINAL:

❑ Loss of appetite ❑ Excessive hunger ❑ Excessive thirst ❑ Difficulty swallowing
❑ Heart burn ❑ Peptic ulcer ❑ Persistent nausea ❑ Vomiting
❑ Abdominal pain/chronic ❑ Gallbladder problem ❑ Liver problem ❑ Jaundice
❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ Cirrhosis
❑ Diarrhea ❑ Diverticulosis ❑ Crohn's/colitis ❑ Bloody or black stools
❑ Heartburn/Reflux esophagitis ❑ History of Stomach Ulcer ❑ Other_____

BLADDER, KIDNEY:

❑ Frequent urination ❑ Bladder infections-frequent ❑ Blood in urine ❑ Kidney stone
❑ Renal failure ❑ Swelling feet ❑ Kidney Failure ❑ Dialysis # years_____

FEMALE:

❑ Sexual transmissible disease ❑ Breast cancer ❑ Ovarian cancer
❑ Postmenopausal ❑ Oral contraceptives

MALE:

❑ Sexual transmissible disease ❑ Prostate cancer

HEMATOLOGIC (BLOOD DISORDERS):

❑ Anemia ❑ Bruise easily ❑ Bleeding Disorder ❑ Blood transfusion
❑ Sickle cell disease/trait ❑ Take Coumadin/Aspirin ❑ Excessive Bleeding/After Surgery

ENDOCRINE:

❑ Diabetes ❑ Thyroid disease ❑ Osteoporosis
❑ Other_____

NEUROLOGICAL (NERVOUS):

❑ Seizures ❑ Tremor/hands shake ❑ Headaches-frequent
❑ Change in memory ❑ Trouble with balance ❑ Spine disease ❑ Sciatica
❑ Numbness ❑ Muscle weakness ❑ Polio ❑ Change in sensation
❑ Stroke

BONE AND JOINT:

❑ Arthritis/Rheumatism ❑ Back pain-recurrent ❑ Gout ❑ Osteoporosis
❑ Osteomyelitis ❑ Rheumatoid arthritis ❑ Bone Infection ❑ Artificial joints_____
❑ Arthritis of TMJ (jaw) or neck ❑ Osteoarthritis

SKIN:

❑ Rashes ❑ Hives ❑ Psoriasis ❑ Eczema
❑ Skin cancer ❑ New growths ❑ Color change-Mole/Wart
❑ Other_____ ❑ Thick scar or keloid formation

PSYCHIATRIC:

❑ Sleeping difficulty ❑ Concentration difficulty ❑ Depression ❑ Nervousness
❑ Agitation ❑ Memory loss ❑ Moodiness ❑ Suicidal thoughts
❑ Phobias ❑ Mental Illness ❑ Feelings of worthlessness
❑ Bipolar ❑ Anxiety ❑ Other_____

CHILDHOOD ILLNESS:

❑ Rheumatic fever ❑ Scarlet fever ❑ Chickenpox ❑ Mumps
❑ Measles ❑ Herpes

ALLERGY/IMMUNOLOGY:

❑ Hay fever ❑ Grass, mold, dust ❑ Food allergies ❑ HIV
❑ Weak immune system ❑ Chronic fatigue syndrome ❑ Frequent infections

H.I.V. POSITIVE? YES ❑ NO ❑
HEPATITIS? YES ❑ NO ❑

ANY INFECTION/PAST 6 MOS? YES ❑ NO ❑
OTHER (PLEASE SPECIFY)_____

PLEASE CIRCLE ANY KNOWN ALLERGIES

PENICILLIN NOVOCAINE CODEINE LOCAL ANESTHESIA TAPE

MURCURIALS SULFA DRUGS ASPIRIN OTHER ANTIBIOTICS NONE

OTHER KNOWN ALLERGIES _____ _____

Wound Healing History: Have you taken Cortizone in the past year Yes _____ No _____
If Yes how long _____

Reason for taking Cortizone?
❑ Rheumatoid Arthritis
❑ Asthma
❑ Other _____

❑ How have your wounds healed or your previous surgeries healed?

_____

_____

Do you have any artificial joints? Hip Yes_____ No_____
Knee Yes_____ No_____
Other Yes_____ No_____

Do you have a Heart Valve Implant? Yes_____ No_____

PLEASE LIST ANY MEDICATIONS NOW BEING TAKEN (WITH DOSAGE)

NAME OF MEDICINE	REASON FOR TAKING IT?	HOW OFTEN DO YOU TAKE IT?

Have you taken Prednisone over the past 6 months? ❑ Yes ❑ No

PREVIOUS SURGERIES (WITH APPROXIMATE DATES)

FAMILY MEDICAL HISTORY:

Mother	❑ Living	❑ Deceased	Cause of Death_____
Father	❑ Living	❑ Deceased	Cause of Death_____
Brother	❑ Living	❑ Deceased	Cause of Death_____
Sister	❑ Living	❑ Deceased	Cause of Death_____

FAMILY MEDICAL HISTORY:

Has anyone in your family ever been treated for:

	You	Father	Mother	Brothers	Sisters	Children	Grandparents	Aunt/Uncle
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Foot Problems	❑	❑	❑	❑	❑	❑	❑	❑
Gout	❑	❑	❑	❑	❑	❑	❑	❑
Neuromuscular disease	❑	❑	❑	❑	❑	❑	❑	❑
Peripheral Vascular disease	❑	❑	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑	❑	❑
Varicose Veins	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑

Do you smoke? ❑ Yes ❑ No # packs per day _____

Previously smoked? ❑ Yes ❑ No # of years_____

Do you drink alcohol or beer? ❑ Yes ❑ No

If Yes, how much ❑ 1-2 per week ❑ 1-2 per day ❑ more than 2 daily

EMPLOYMENT HISTORY and SHOES:

Employment: ❑ Sits at job ❑ Stands at job ❑ Stands & walks at job ❑ Retired

Does the employer require any particular type of shoes? Boots_____ Heels_____ Other_____ N/A_____

After work: ❑ Goes home and sits ❑ Goes home and exercises Type of exercise _____

Length of time _____

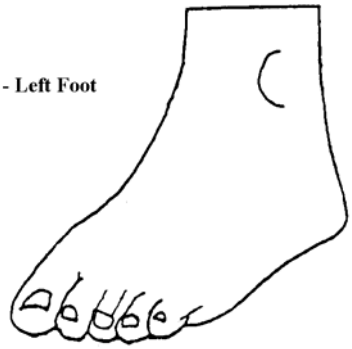
CURRENT WEIGHT_____ **CURRENT HEIGHT**_____

Description of Problem

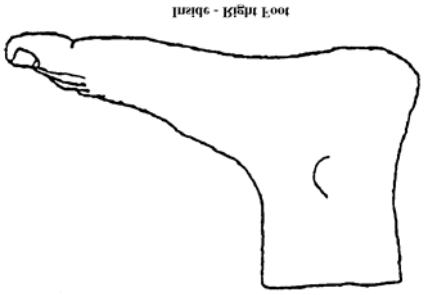
On the diagrams below, please mark the place(s) where you are experiencing pain in your feet:

Inside - Left Foot

Bottom - Left Foot

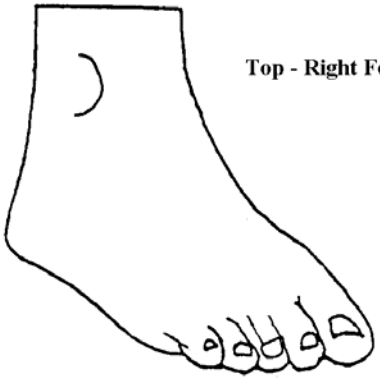


Top - Left Foot



Inside - Right Foot

Bottom - Right Foot



Top - Right Foot

Regarding the place(s) you marked above, describe the pain you experience, for instance, mild, moderate, severe, throbbing, burning, etc. and the time of day if occurs:_____

What is your foot problem? _____

How long have you been bothered by foot problems? _____

_____

How would you describe the pain you are having?_____

_____

How is this condition limited your activities? _____

Have you seen another doctor for your foot problems? _____

Did you see a foot doctor or a family doctor? _____

Name of previous doctor who treated your foot problem? _____

Patient Signature_____ **Date**_____

Reviewed by Dr. Glass _____ **Date** _____