

WELCOME TO OUR PRACTICE

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # _____ DATE OF BIRTH _____ AGE _____

EMPLOYED BY _____ Occupation _____ Work # _____

SOCIAL SECURITY _____ / _____ / _____ SEX _____ MARITAL STATUS _____

PRIMARY INSURANCE _____ POLICY NUMBER _____

SUBSCRIBER _____ DATE/BIRTH _____ REALTIONSHIP _____

2ND INSURANCE (IF APPLICABLE) _____ POLICY NUMBER _____

SUBSCRIBER _____ DATE/BIRTH _____ RELATIONSHIP _____

REFERRED BY _____ PRIMARY/FAMILY DOCTOR _____

HEALTH HISTORY

BRIEFLY STATE YOUR FOOT PROBLEM _____

PLEASE CIRCLE: *LEFT FOOT* *RIGHT FOOT* *BOTH FEET* DURATION _____

PLEASE CHECK BELOW IF YOU HAVE EVER HAD OR DO HAVE ANY OF THE FOLLOWING

- | | | |
|---------------------------|-----------------------------|---------------------|
| _____ High Blood Pressure | _____ Diabetes | _____ Heart Disease |
| _____ Bone Problems | _____ Asthma | _____ Tuberculosis |
| _____ Stomach Disorders | _____ Cancer | _____ Arthritis |
| _____ Rheumatic Fever | _____ Neurologic Disorders | _____ Skin Disease |
| _____ Phlebitis | _____ Psychiatric Disorders | _____ Gout |
| _____ Kidney Disease | _____ Eye Disease | _____ Epilepsy |
| _____ Liver Disease | _____ High Cholesterol | _____ Blood Clots |

ARE YOU SUBJECT TP PROFUSE BLEEDING? YES _____ No _____

ARE YOU CURRENTLY PREGNANT? YES _____ NO _____ BIRTH CONTROL PILLS _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES ___ NO ___ PURPOSE? _____

ALLERGIES TO MEDICATIONS

LIST ALL SURGERIES _____

LAST VISIT TO FAMILY PHYSICAN _____