PATIENT INFORMATION

Name: _____ _____
Last First MI Birthday

Address: _____
Street

_____
City State Zip
Phone: (Home) _____ (Work) _____ (Cell) _____

M _____ F _____ Social Security: _____ Marital Status: S M O

Emergency Contact: _____ ___ Phone/Cell Number: _____

Race:
___American Indian or Alaska Native
___Asian
___Black or African American
___Native Hawaiian or Other Pacific Islander
___White

Ethnicity:
___Hispanic or Latino
___Not Hispanic or Latino

Pharmacy Name & Address: _____ Pharmacy Phone: _____

Insurance Information

Primary Insurance: _____ I.D. Number_____

Full Name of Insured: _____ DOB: _____

Secondary Insurance: _____ I.D. Number_____

Full Name of Insured: _____DOB:_____

Signature: _____ Date: _____
(Patient or legally responsible adult)

(TURN OVER)

Referred by: _____

Primary Care Physician: _____**Last Visit:** _____

Height _____ **Weight** _____ **Last Blood Pressure** _____/_____

What foot problems are you having: _____

_____

Review of System
Circle Yes or No

Are you Pregnant?	yes no	High Blood Pressure	yes no
Arthritis	yes no	HIV Virus	yes no
Asthma	yes no	Kidney Problems	yes no
Back Problems	yes no	Loss of Balance	yes no
Bladder Problems	yes no	Numbness / Tingling	yes no
Bleeding Disorders	yes no	Persistent Cough	yes no
Cancer	yes no	Pneumonia	yes no
Chest Pain	yes no	Shortness of Breath	yes no
Diabetes	yes no	Stomach Problems	yes no
Emphysema	yes no	Stroke	yes no
Epilepsy	yes no	Ulcers	yes no
Headaches	yes no	Blood Sugar #: _____	
Heart Attack	yes no		
Hepatitis	yes no		

Other Medical Problems:

_____

_____

Have you had any Complications with surgeries and/or anesthesia? yes no

Explain: _____

Alcohol: no <2 4 6 Drinks per week.

Smoke: no <1 2 3 Packs per Day.

Family Medical History: (Diabetes, High Blood Pressure, Cancer, etc.)

_____

Allergic to:

Penicillin yes no **Sulfa** yes no **Adhesive Tape** yes no **Local Anesthesia** yes no
Latex yes no Allergic to other meds: _____

_____

Medications now taking: _____

_____

_____