PATIENT HISTORY

Welcome to our office! Date:

*** <u>This form MUST be fully completed by patient, patient guardian or patient advocate</u> ***

Patient's Name _____ Spouse _____

Address _____
(Street) (City) (State) (Zip Code)

Social Security # _____-_____-_____ Date of Birth _____-____-_____ Marital Statis _____

Home Phone ____-____-_____ Cell Phone ____-____-_____ Work Phone ____-____-_____ (ext) _____

Email _____ Person responsible for account _____

Occupation _____ Employer _____

Referred by _____ Referring Physician's Address_____

Please answer <u>all</u> the following questions to the best of your ability:

_____ I am NOT allergic to anthing to my knowledge.

I am allergic to: (circle all that apply)

Antihistamines
Aspirin
Codeine
Demerol
Penicillin
Sulfa
Novocain
Xylocaine
Adhesive
Iodine
Latex
Metals,Jewelry
Nylon,Plastics
Other (specify)

I now have or have had the following: (circle all that apply)

AIDS, HIV
Anemia
Asthma
Arthritis (Type:_____
Bleeding tendencies
Cancer
Diabetes
Epilepsy
Gout
Heart trouble
Hepatitis
High blood pressure
Kidney trouble
Leg cramps
Nervousness
Stomach Ulsers
Stroke
Tuberculosis
Tumors
Varicose veins, clots
Other (specify)\

What is your current? Height _____ Weight _____ Shoe size _____ Are you pregnant or breast feeding? Yes/No
Present state of health? Good _____ Fair _____ Poor _____ If fair or poor, why? _____
What is your level of activity? High _____ Medium _____ Low _____
Are you currently on a special diet? Yes/No If yes, why?_____
Are you presently under a doctors care? Yes/No If yes, why?_____

Please list all medications you are currently taking AND dosage(s):

_____ dose: _____
_____ dose: _____
_____ dose: _____
_____ dose: _____
_____ dose: _____

Please indicate any herbal medications as well: _____

Patients initials: _____
(or guardian/advocate)

PATIENT HISTORY

What brings you to the office today? (chief complaint)
History of this injury: _____

Treatment thus far for this condition:

Pain associated: Mild Moderate Severe _____
Quality of pain: (please circle all that apply)
Dull Burning Sharp Ache Throbbing Shooting Numbness Other _____

History of surgeries: _____
Anesthetic complications: _____.

Do you smoke? Yes / NoIf yes, number of packs per day? ___ Number of years smoking? ___
Do you drink alcohol? Yes / No 1-2 per week __ 1-2 per day __ More than 2 drinks per day __
Do you engage in recreational drug use? Yes / No Occasionally __ Weekly __ Daily __

If you are presently working, do you: Sit at job __ Sit and Stand at job __ Stand at job __ Retired __

FAMILY HISTORY (blood relatives)

	Living	Deceased	Cause of Death	Health Problems
Mother	/			
Father	/			
Brother	/			
Sister	/			
Additional	/			
	/			

Do you have a blood relative with a history of...? Please check all of the following that apply,

Heart Disease	____	Bunions	____
Arthritis	____	Hammertoes	____
Bleeding disorder	_____	Flat Feet	____
Stroke	_____	Circulation problems	
Cancer	_____	_____	in legs or feet

I hereby give permission to Drs. Watson, Duncan, Blackerby, or such associates and assistants as may participate with them, to examine and treat my feet medically, surgically, and/or orthopedically. By signing below, I authorize this as my "signature on file" for treatment, all insurance submissions, and release of information to my insurance companies,

_____

Signature of Patient (or guardian if patient is a minor, or patient advocate) Date

_____

Printed Name of Patient

Office Received date:

Staff Member Initial: