

Welcome to Friendly Foot Care
Please Provide the Following Important Medical Information to the Best of Your Ability

Patient Name: _____ Date: _____

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

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

Past Medical History:

1. Please check the "Yes" or "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"/> | _____ |
| Bleeding/Blood Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Skin Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | |

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

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, ointments):

Social History:

Height? _____ Weight? _____ (circle) Are you underweight obese overweight correct weight or unsure?

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? _____

How would you describe your mood (i.e. happy, calm, anxious etc.)? _____

Family History:

1. 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"/> | _____ | Heel spurs/heel pain | <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"/> | _____ | Bunions | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Flatfeet | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Neurological Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bleeding/Blood Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other Foot/Ankle Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other Medical Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | |

Patient Name: _____ Date: _____

Review of Systems: 1. Please check the "Yes" or "No" box if you have any of the following symptoms.
 2. Please check the "Current box" if you are currently experiencing this symptom.

| | | <u>YES NO CURRENT</u> | | | | | <u>YES NO CURRENT</u> | | |
|------------------|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| General | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes | Eye Pain/pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Chills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Vision Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Weight Loss or Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Eye Redness/Drainage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Daytime Sleepiness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <hr/> | | | |
| | Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Ears/Nose/Throat | | | |
| Allergy | Environmental Allergy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Sneezing Fits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neuro | Any Numbness/Tingling in feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Throat Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Numbness/Tingling elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Snoring Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Any Burning in feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oral Sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Burning elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear Ache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> | | | | |
| | Shooting Pain in Feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory | | | | |
| | Shooting Pain Elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Tremors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coughing Up Blood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cardiac | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Leg Cramps when walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> | | | | |
| | Leg Cramps in bed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hematological/Lymphatic | | | | |
| | Swelling of feet/ankles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gastrointestinal | | | | | Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> | | | | |
| | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine | | | | |
| | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feels Warmer Than Others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Black or Bloody Stools | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feels Colder Than Others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heat Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin | Rash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wakes Often to Urinate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Any Open Sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> | | | | |
| | Warts on feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary | | | | |
| | Warts Elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain on Urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Other Lesions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Fungal Toe Nails | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Urinary Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Fungal Fingernails | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Groin Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Dry Skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <hr/> | | | | |
| | Abnormal Moles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle-Skeletal | | | | |
| Psych | Infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Other Skin Changes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Hair Changes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Easily Loses Temper | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Drug/Alcohol Dependence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Memory Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Confusion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any Limited Joint Motion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

Family Physician: _____ Last Visit Date: _____

Family Physician Address: _____

Cardiologist: _____ Last Visit Date: _____

Neurologist: _____ Last Visit Date: _____

List other foot/ankle doctors seen: _____

Name of person filling this out, if not the patient: _____

Welcome to Friendly Foot Care
Please Provide the Following Important Information to the Best of Your Ability

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Cellular: (____) _____ Work: (____) _____

Patient's SSN: _____ - _____ - _____ Patient's Birthday: ____/____/____

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

In Case Of Emergency, Notify (please provide two names):

1. _____ Phone: (____) _____

2. _____ Phone: (____) _____

Employer _____ Phone: (____) _____

Employer Address: _____ City, ST, Zip _____

How did you hear of us? (Circle one): Internet Newspaper Yellow Pages
Another Patient Doctor

Please indicate which Newspaper ad/patient/doctor? _____

Referring Doctor _____ Nursing Home _____

INSURANCE INFORMATION

Insured's Name: _____

(THE PERSON'S NAME ON THE INSURANCE CARD AS THE SUBSCRIBER)

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Insured's SSN: _____ - _____ - _____ Insured's Birthday: ____/____/____

Spouse's Name: _____ Spouse's Work Phone :(____) _____

Primary Insurance Company Name: _____

ID # _____ Group #: _____ Plan: _____

Secondary Insurance Company Name: _____

ID # _____ Group #: _____ Plan: _____

I attest that I have provided accurate health insurance information for coverage or benefits for medical care. Also, I have no other medical insurance other than what I have listed above. I authorize payment of medical benefits to my physician for services rendered.

(Signature of insured or authorized person)

DATE _____