Family Foot
— Health Care PLC —

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MANAGEMENT OF FOOT & ANKLE DISORDERS

Name _____ Soc. Sec. No. _____

Date of Birth _____ Age _____ ❑ Male ❑ Female ❑ Non Binary Marital Status _____

Physical Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____

Home/Cell Phone _____ Work Phone _____ Preferred Pharmacy _____

Email Address _____

Race: ❑ Not Specified ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino

How would you like to be contacted regarding health information: ❑ Phone ❑ Email ❑ Mail

Who are we able to talk to on the phone: ❑ Patient only ❑ Patient and/or Spouse ❑ Anyone Answering the Phone

Name of Spouse or Parent _____

Next of Kin/Emergency Contact (name and phone) _____

How were you referred to the office? Patient _____ Doctor's Office _____ Media _____

Family Doctor _____ Date of last visit _____

Employer _____ Employer Phone Number _____

Employer Address _____ Position _____

INSURANCE INFORMATION

Type of Insurance _____ Policyholder _____

Member ID _____ Group Number _____

Policyholder Birth date _____ Policyholder Soc. Sec. No. _____

Policyholder Address _____

Relationship to Patient _____ Policyholder Employer _____

Employer Address _____

Employer Contact & Phone Number _____

Name: _____ Date of Birth: _____ Date: _____

CHIEF COMPLAINT - Why are you coming to the doctor today?

_____

Is this condition work related? ❑ Yes ❑ No Did this injury occur at school? ❑ Yes ❑ No

Is this condition auto related? ❑ Yes ❑ No Injury or Trauma? ❑ Yes ❑ No
Date of Injury: _____ What happened? _____

_____

Type of Problem

❑Corns, Callous, Nails	❑ Fracture/Sprains	❑ Warts, Tumors	❑ Bunions, Hammertoes
❑Diabetic Foot Care	❑ Ingrown Nail	❑ Ankle Pain	❑ Neuroma or Nerve Pain
❑Other	❑ Injury	❑ Numbness	

When did the pain start? _____ Describe Pain. _____

Where does it hurt? ❑ Right ❑ Left ❑ Both When does it hurt? _____

_____ _____

Previous episodes? _____ Previous treatment and response? _____

_____

Allergies Do you have any allergies to medications / environment / food? ❑ Yes ❑ No
❑ NSAIDS ❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Aspirin
❑ Novacaine ❑ Anesthetics ❑ Iodine ❑ Adhesives ❑ Metal or Nickel
❑ Environmental Other: _____ Type of reaction _____
Are you allergic to latex products? ❑ Yes ❑ No

Medications List all prescription medications you take; include dosage and frequency. Insulin, inhaler, and patches should be included here.

_____
_____
_____
_____
List all non-prescription medications you take routinely _____

Family History List illnesses or health issues. Any Family History of:
Mother's Side of the family: ❑ Blood Clot ❑ Diabetes ❑ High Blood Pressure ❑ Cancer
❑ Other: _____
Father's Side of the family: ❑ Blood Clot ❑ Diabetes ❑ High Blood Pressure ❑ Cancer
❑ Other: _____

Social History Shoe Size _____

Do you or have you ever smoked? ❑ Yes ❑ No How Much _____
**If you quit smoking, how long ago did you quit?* _____
Do you drink alcohol? ❑ Yes ❑ No How Much _____
Do you or have you ever used illegal substances? ❑ Yes ❑ No ❑ Current User ❑Former User
What type of current/former occupation do/did you have? _____

Are you Disabled? ❑ Yes ❑ No Type / Nature of Disability _____

Name: _____ Date of Birth: _____

Past Surgical History Have you had any surgery before? ❑ Yes ❑ No
If yes, please list procedure and date _____
_____
_____
_____

Past Medical History Do you have a history of any of the following?

❑ High Blood Pressure	❑ Diabetes	❑ Stroke	❑ Nervousness	❑ Blood Clot
❑ Circulation Trouble	❑ High Cholesterol	❑ Gout	❑ Osteoporosis	❑ Glaucoma
❑ Heart Trouble	❑ Liver Disease	❑ Sleep Apnea	❑ MRSA	
❑ Kidney Disease	❑ Neuropathy	❑ Thyroid Disease	❑ Hepatitis	
❑ Rheumatoid Arthritis	❑ Leg Cramps	❑ Varicose Veins	❑ Alzheimer's Disease	
❑ Arthritis	❑ Dementia	❑ Depression	❑ COVID-19	
❑ Cancer Type: _____		❑ Other: _____		

CONSTITUTIONAL
❑ Fever
❑ Weight loss intentional
❑ Weight loss unintentional
❑ Fatigue

CARDIOVASCULAR
❑ Chest pain (angina)
❑ Heart palpitations
❑ Heart attack
❑ Cold extremities
❑ Congestive Heart Failure
❑ Mitral Valve Prolapse

ENDOCRINE
❑ Night sweats
❑ Heat intolerance
❑ Cold intolerance
❑ Frequent thirst

GASTROINTESTINAL
❑ Pain
❑ Diarrhea
❑ Constipation
❑ GERD / Heart Burn
❑ Food intolerance
❑ History of Ulcers
❑ GI Intolerance

GENITOURINARY
❑ Frequent urination
❑ Frequently blood in urine
❑ Painful urination
❑ Incontinence

INTEGUMENTARY
❑ Rash
❑ Itching
❑ Dry Skin
❑ Toenail/Fingernail changes

HEMATOLOGIC/LYMPHATIC
❑ Easy bruising
❑ Anemia
❑ Blood abnormalities
❑ Blood thinners
❑ HIV / AIDS
❑ Hepatitis

MUSCULOSKELETAL
❑ Pain -
❑ Muscles ❑ Neck
❑ Back ❑ Hips
❑ Knees ❑ Ankles ❑ Foot
❑ Limited range of motion
❑ Limited strength
❑ Fibromyalgia

NEUROLOGICAL
❑ Headache
❑ Fainting
❑ Dizziness
❑ Memory loss
❑ Numbness
❑ Parkinson's
❑ Epilepsy

PSYCHIATRIC
❑ Temper
❑ Bipolar
❑ Anxiety

RESPIRATORY
❑ Shortness of breath
❑ Tuberculosis
❑ Emphysema
❑ COPD
❑ Asthma

Are your Immunizations Up-to-date: ❑ Yes ❑ No

Have you had any of these vaccines:
❑ COVID-19 Vaccine
❑ Flu Vaccine
❑ Pneumonia Vaccine
❑ Shingles Vaccine

❑ Eyes _____
❑ Ears _____
❑ Nose _____
❑ Throat _____

Unmarked box indicates that the patient denies this problem.