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FAMILY FOOT & ANKLE PHYSICIANS, PLLC

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Welcome to our office. Please print your responses to the following questions. This is a part of your medical record.

Full Name ____ Today's Date _______________________

Home phone ______________________ Cell _______________________ Work phone _______________________

Address (Physical Location) ____

City/State/9 digit Zip___________________________________ Email Address:____________________________

Mailing Address if different from above____

City/State/Zip____

Sex: F M Birth date __________ Age _______ Social Security # _______________________________

Race/Ethnicity ____________________________________

Marital Status (Please circle one): Single Married Divorced Widowed

Employer Name: __________________________________Occupation_________________________________
Employer Address: ____

Emergency contact (other than someone living with you):
Name ___________________________________ Relationship __________ Phone _________________________

Name of medical and/or surgical insurance companies under which you are covered:

1. ____
   Through self ________ spouse ________ work ________ parent ________
   Insured's Date of Birth: _________________________ (If other than THROUGH SELF)
2. ____
   Through self ________ spouse ________ work ________ parent ________
   Insured's Date of Birth: _________________________ (If other than THROUGH SELF)

How did you find out about our office? ____

MEDICAL INFORMATION

Primary Care Physician's Name and Phone Number:____
____

Date of last visit with your PCP: ________/________/________ (month/day/year)

Are you currently under your doctor's care? Yes No
If so, for what reason? ____

What is your Height? ________________Weight? _______________ Shoe size? ____________________________

Have you had previous treatment by a podiatrist? Yes No When? ______________________________
For what reason? ____
What is the reason for your visit today? ____
Do you now have or have you ever had any of the following? Please check all that apply.

O Anemia
O Arthritis
O Asthma
O Bleeding problems
O Blood disease
O Breathing/Lung problems
O Cancer
O Diabetes
O Epilepsy
O Fainting spells
O Glaucoma
O Heart trouble
O High blood pressure
O High Cholesterol
O Kidney disease
O Leg cramps
O Liver disease
O Muscle disease
O Nervousness
O Pacemaker
O Polio
O Rheumatic/Scarlet fever
O Skin rashes
O Stomach/intestinal ulcers
O Stroke
O Thyroid disease
O Tuberculosis
O Varicose veins
O Other (please specify) ____________________

Does any of your immediate family (father, mother, sister, brother, grandparents) have any of the above conditions? Please list: -
____
____

Pharmacy ____

Please list *all* medications you are taking including aspirin and birth control: ______________________________
____
____
____

ALLERGIES Are you allergic to . . . ______No known allergies

_____ Novocaine _____ Codeine _____ Adhesive tape _____ Sulfa _____ Foods
_____ Penicillin _____ Iodine _____ Other ____
____

Do you smoke? _____ How many packs per day? ________________
Do you use alcohol? _____ How much do you drink per week? _____
Do you use street drugs? _____ Please name ____________________
Have you been in contact with the AIDS virus? ____________________
Have you had a Flu Vaccine in the last 12 months ?__________
Have you had a Pneumonia Vaccine in the last 5 years ?__________
Please list and date any surgeries you've had since childhood.
____
____
Is there anything else we should know about your general health?
____
I certify that the above information is true and correct to the best of my knowledge. I hereby give Dr. Stancil, Dr. Pitzer, Dr. Chen, and/or Dr. Jones permission to administer and perform such procedures as may be deemed necessary to diagnose and/or treat my feet/ankles. Also, I understand that photographs and/or X-rays may be taken of my feet/ankles and are a part of my permanent medical record.

____ ____________________
Signature Date
(Signature of Parent or Guardian if under 18 years of age)