Patient Podiatric and Health Information

Family Physician _____

Last Visit _____

What is the nature of your foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____

Are you in good general health? ☐Y ☐N If no, explain _____

_____

Are your feet tired at the end of the day? ☐Y ☐N Do you have lower back pain? ☐Y ☐N

Have you ever broken a bone in your foot or ankle? ☐Y ☐N Have you had previous foot/ankle surgery? ☐Y ☐N

Do you use tobacco products? ☐Y ☐N If yes, what amount daily? _____

_____

Medical History

Check (✓) if you have had any of the following:

- ☐ Arthritis, Rheumatism
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Eye trouble
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Swelling of feet or ankles
- ☐ Varicose veins

Are you allergic/sensitive to:

- ☐ Anesthetics
- ☐ Drugs
- ☐ Foods
- ☐ Materials
- ☐ Novocaine
- ☐ Penicillin
- ☐ Tape
- ☐ Other

List medications you are currently taking, if any:

_____ _____

_____ _____

_____ _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.