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Podiatric Physician & Surgeon Board Certified in Foot Surgery
Diplomate, American Board of Podiatric Surgery Fellow, American College of Foot Surgeons

Name:____ DOB:_________________ Today's Date:________________

Parent/Guardian Name:____

Local Address____City______________________St_____Zip__________

Home #___________________________Cell #__________________________Other #_________________________

Northern /Other Address_______________________________________City___________________St_____Zip_________

Which Address does your primary insurance have on file as your home address? ____Florida ____Other/Northern

Date you arrive in Florida (Approx) ___________ Date you leave Florida (Approx)___________

Sex: __M __F Marital Status: __Single __Widowed __Divorced __Married (Spouse Name__________________________)

Emergency Contact Name_______________________________Telephone#________________________

E-mail Address:____ (Needed if you want to access your electronic medical records)

Employer:____Tele#____________X_____Occupation:______________________

How did you find out about our practice? Referred by Dr.____

___Internet ___Family/Friend ___Church Bulletin ___Advertisement ___Phone book ___Insurance Co

What is the reason for your visit today? ____

Is your injury the result of an accident/auto/work injury? ____No ___Yes (Date of Injury? ____________________)

How long has this bothered you? 1 2 3 4 5 6 7 ___days ___weeks ___months ___years

On a scale of 1-10 (1 being no pain and 10 being the worst pain) what is your pain level? _____/10

The pain quality is: __burning __sharp __shooting __throbbing __tingling __constant __dull __ache Other_____________

Pain is present when: __barefoot __in shoes __standing __walking __sleeping __exercising __climbing __first steps after rest

Pain in my feet/legs limits me when: __walking __running __dancing __gardening __biking __exercising Other_______________

What treatments have you tried & have they been effective?____

Current Height:__________ Current Weight:____________ Blood Pressure (if known)_________/___________

I currently: __walk without assistance __walk with assistance (arm support/cane/walker/crutches) __use a wheelchair

Shoe size: ________ Narrow/Med/Wide/X-Wide/_____ Shoe preferred: Walking/Dress/Athletic/Heels/Casual____________

Do you wear shoe inserts?__ No __ Yes __Custom orthotics __Over the counter supports __Diabetic insoles ________________

Have you fallen in the last 12 months? __No __Yes-were you injured? __No __Yes-how?____________________________

Primary Care Physician: Dr.________________________________ Phone:_________________Date Last Seen:______________

Address_______________________________________ City____________________________ State________Zip____________

Endocrinologist/Cardiologist:__________________________________ Phone:________________ Date Seen:______________

Address_______________________________________ City____________________________ State________Zip____________

Pharmacy___________________________Address (cross-streets) __________________________________ #___________________

Did you get a pneumococcal vaccine? __Yes __No Last flu shot date:________ or __Declined for medical/personal reasons

Advanced Directives: ___None ___DNR ___Living Will ___Durable Power of Attorney ___Health Care Surrogate Appointed

Do you have reason to be exempt from public reporting? __No __Yes Can we send mail to address on file? __Yes __No

Can we call the phone # on file? __Yes __No Can we leave a voicemail __Yes __No May we send e-mail delivery of reminders and newsletters? __Yes __No Who can we leave messages with? ____