Patient Information

Name: _____ Height _____ Weight _____

Birthdate_____ Male☐ Female☐

Reason for your visit? _____

1. Are you in good health? Y N

2. Do you smoke? Y N

3. Have you had previous care by a foot specialist? Y N

4. Are you now or have you been under a physicians care in the last 2 years? Y N

5. Have you taken cortisone within the last year? Y N

6. Are you subject to prolonged bleeding? Y N

7.Are you presently taking any medication? Y N

If so, what? _____

8. Are you allergic to any medication? Y N

9. Do you have a family history of diabetes? Y N

10. Are you HIV positive? Y N

11. Are you a hepatitis carrier? Y N

12. Have you ever been treated for heart trouble, asthma, epilepsy, rheumatic fever,

13. Kidney or liver involvement, or high blood pressure? Y N

14. Have you had any serious illness or operations? Y N

15. Have you broken a bone in your feet or legs? Y N

16. Do you faint easily? Y N

I hereby give permission to examine, perform diagnostic tests, and treat my feet or ankles medically, surgically or orthopedically. I also authorize the release of any information needed to process this claim.

Signature _____ Date _____