PRINT

DUBUQUE PODIATRY – PATIENT INFORMATION

SAVE

Date _____

Name _____ _____ _____ Sex: F M
First Middle Last

Birth Date _____ Age _____ SS#_____ Marital Status S M W D

Address _____ Cell Ph # (_____) _____

City _____ State _____ Zip _____ Phone # (_____) _____

Place of Employment _____ Phone # (_____) _____

Emergency Contact _____ Phone # (_____) _____

Referred by _____

If Patient is a Minor, please complete this section

Father's Name _____ _____ _____ D.O.B. _____ SS# _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Father's Employer _____ Phone # (_____)_____

Mother's Name _____ _____ _____ D.O.B. _____ SS# _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Mother's Employer _____ Phone # (_____)_____

If Patient is Married, please complete this section

Spouse's Name _____ _____ _____ D.O.B. _____ SS# _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Primary Insurance

Ins. Name _____ Subscriber _____

ID# _____ Group # _____ Co-Pay _____ Effect. Date _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance

Ins. Name _____ Subscriber _____

ID# _____ Group # _____ Co-Pay _____ Effect. Date _____

Address _____ City _____ State _____ Zip _____

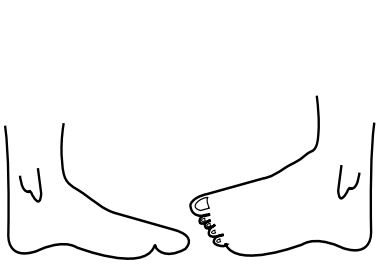
Additional Insurance _____

PLEASE SIGN

I authorize Dubuque Podiatry P.C. to treat my and my dependents foot/ankle problem. I authorize the release of Medical information necessary to process this claim. I authorize the payment of medical benefits to Dubuque Podiatry. I understand that I am responsible for all costs of treatment.

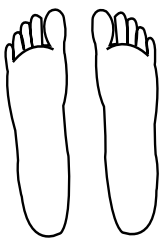
X_____ Relationship _____

Please mark with an "X" where your pain is located on your feet:

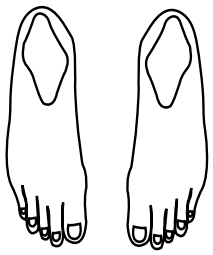


Inside Foot left or right

Outside Foot left or right



R L Bottom View



R L Top View

Back of Leg left or right

Front of Leg left or right

Race

- Caucasian
- American Indian
- African American
- Hawaiian/Pacific Islander
- Asian
- Other: _____

Ethnicity

- Hispanic/Latino
- Non-Hispanic/Latino

Language: _____

Foot Problem or Symptoms: _____
(Please describe in your own words)

_____

_____

How long have you had this problem? _____Days _____Weeks _____Months _____Years

Medical History

	Yes	No
1. Heart Problems		
☐ Mitral Valve Prolapse ☐ Heart Attack		
☐ Stroke ☐ Other		
2. Diabetes	☐	☐
If Yes-How Do You Control Your Diabetes		
Diet Pills Insulin		
Any member of family that had diabetes?	☐	☐
If so, how related? _____		
3. Lung Problems:		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Other	☐	☐
4. Liver Problems:		
Hepatitis	☐	☐
Jaundice	☐	☐
Other	☐	☐
5. Circulation Problems:		
Varicose Veins	☐	☐
Phlebitis (Blood Clots)	☐	☐
Peripheral Vascular Disease	☐	☐
Poor Circulation	☐	☐

	Yes	No
1. High Blood Pressure	☐	☐
2. Low Blood Pressure	☐	☐
3. Ulcers	☐	☐
4. Arthritis	☐	☐
5. Gout	☐	☐
6. High Cholesterol Levels	☐	☐
7. Cancer (Type_____)	☐	☐
8. Epilepsy or Seizure Disorder	☐	☐
9. Kidney Problems	☐	☐
10. Thyroid Condition	☐	☐
11. Glaucoma	☐	☐
12. History of Rheumatic Fever	☐	☐
13. Artificial Joint Replacement	☐	☐
Premedication Necessary?	☐	☐
14. Immune System Disorders (Aids, HIV, ARC)	☐	☐
15. Venereal Disease	☐	☐
16. Anemia	☐	☐
17. Prone to Infection	☐	☐
18. Scar Problems	☐	☐
19. Bleeding Disorders	☐	☐

Shoe Size _____ Height _____ Weight _____

Pharmacy Name: _____

Physician Name: _____

Date of Last Visit: _____

	Yes	No
Any Other Medical Problems?	☐	☐
If Yes-Please List _____		
Past or Present Surgeries?	☐	☐
If Yes-Please List _____		
Are you presently taking any medication?	☐	☐

If Yes-Please list or provide a list:

_____

Do you have any medication allergies? _____

Allergies to ☐ adhesive tape or ☐ metals

Do You Smoke?	☐	☐	If Yes-How Much _____ How Many Years_____
Do You Consume Alcoholic Beverages?	☐	☐	If Yes-How Much Per Day/Week _____
Do You Consume Caffeinated Beverages?	☐	☐	If Yes-How Much Per Day/Week _____

How many hours are you on your feet a day? _____

Outside/Athletic Activities? _____