

PATIENT INFORMATION FORM

Welcome to our office. Please take a few moments to carefully fill out this form. This information will better help us to serve you. Thank-you.

NAME _____ STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE Home () _____ Office () _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY# _____

PLACE OF EMPLOYMENT _____

ADDRESS _____

OCCUPATION _____

MARITAL STATUS Single _____ Divorced _____ Married _____ Widowed _____

PERSON RESPONSIBLE FOR PAYING YOUR MEDICAL BILLS?

NAME _____ ADDRESS _____

TELEPHONE () _____ RELATIONSHIP _____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

DO YOU HAVE HEALTH INSURANCE? _____

PRIMARY INSURANCE CO. _____ POLICY# _____ GROUP# _____

OTHER INSURANCE CO. _____ POLICY# _____ GROUP# _____

NAME OF YOUR FAMILY DOCTOR _____

ADDRESS _____ TELEPHONE () _____

DATE OF LAST COMPLETE PHYSICAL EXAM _____

DATE OF MOST RECENT BLOOD WORK _____ CHEST X-RAY _____ EKG _____

HAVE YOU SEEN A PODIATRIST BEFORE? _____ IF SO, FOR WHAT? _____

WHAT FOOT PROBLEM(S) HAS/HAVE CAUSED YOU TO SEEK TREATMENT AT THIS OFFICE?
(DESCRIBE) _____

WHEN DID THIS PROBLEM BEGIN? _____

WHAT DEGREE OF DISCOMFORT ARE YOU EXPERIENCING? _____

HOW WOULD YOU DESCRIBE THE DISCOMFORT? _____

WHEN DOES THE DISCOMFORT OCCUR? _____

WHAT TREATMENT, IF ANY, HAVE YOU TRIED? _____

WHAT TYPE OF SHOEGEAR DO YOU WEAR MOST OFTEN? _____

DO ANY OF YOUR IMMEDIATE RELATIVES HAVE PROBLEMS WITH THEIR FEET? _____

IF SO, PLEASE EXPLAIN _____

(Please fill out other side)

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (PLEASE CHECK)

- | | |
|---|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> POOR CIRCULATION |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> SEIZURE DISORDER | <input type="checkbox"/> ULCER OR OTHER GI PROBLEMS |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> NERVOUS CONDITION |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PHLEBITIS |
| <input type="checkbox"/> HEART DISEASE/HEART ATTACK | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> OTHER _____ |

WHAT MEDICATIONS, IF ANY, ARE YOU PRESENTLY TAKING?

| NAME | DOSAGE | NAME | DOSAGE |
|-------|--------|-------|--------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (PLEASE CHECK)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> ASPIRIN |
| <input type="checkbox"/> ANTIBIOTICS | <input type="checkbox"/> ADHESIVE TAPE |
| <input type="checkbox"/> NOVOCAINE | <input type="checkbox"/> IODINE |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> OTHER _____ |

LIST ANY HOSPITALIZATIONS/SURGERIES YOU HAVE HAD (INDICATE DATES) _____

DO YOU SMOKE? _____ # PACKS PER DAY _____ # OF YEARS SMOKED _____

HAVE YOU EVER HAD A PROBLEM WITH ALCOHOL/DRUG ABUSE? _____

ARE YOU PRESENTLY PREGNANT? _____ IF SO, DUE DATE _____

DO ANY OF YOUR IMMEDIATE RELATIVES HAVE DIABETES, HIGH BLOOD PRESSURE, BLEEDING DISORDERS, ANEMIA, HEART DISEASE OR CIRCULATORY PROBLEMS? _____

IF SO, PLEASE EXPLAIN _____

DO YOU ENGAGE IN ANY ATHLETIC ACTIVITY ON A REGULAR BASIS? _____

IF SO, PLEASE EXPLAIN _____ SHOE SIZE _____

I HAVE READ THE ABOVE QUESTIONS AND ANSWERED THEM TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE DR. GRIPPO TO EXAMINE ME. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE DATE

(Please do not write below this line)

HEIGHT _____ WEIGHT _____ BP _____ TEMP _____