**Thank you for contacting *Family Foot Care Center* for your upcoming Podiatry Appointment. Your appointment is:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_with **Dr. Robert Peel Dr. Douglas Ring**

**Date of your appointment** **Time**

* **COMPLAINT:**

NAME Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male Female

Significant Other’s Name

Address City Zip

**Home Phone** Work Phone

**Email Address**

* **Primary Care Physician:** Date of last visit:

Primary Insurance Subscriber Name: DOB

**(If different from patient)**

Secondary Insurance Subscriber Name: ID#

**PATIENT HISTORY**

**NO HEALTH ISSUES:**

Arthritis

Artificial Joint(s)

Asthma

Bunion(s)

Cancer

Circulation Issues

Diabetes Type 1

Diabetes Type 2

Flat Feet

Frequent Infections Gout

Hammertoe(s)

Heart Disease/Attack

Hepatitis

High Blood Pressure

High Cholesterol

Skin Cancer

**Smoker (PRESENT)**

**Smoker (Past)**

**Social Alcohol Use**

STD (Past or Present)

Stomach Ulcer

Stroke

Tuberculosis

Other:

HIV Positive

Hypothyroidism

Intestinal Issues

Kidney Issues

Liver Issues

Lung Difficulties

Neuropathy

Neurological Disorder

Parkinson Disease

**IMMEDIATE FAMILY HISTORY -  NONE (or check boxes below) Mother or Father**

Adopted with no history Circulation Issues M/F Heart Disease M/F Neurological Disorder M/F

Arthritis M/F Cancer M/F Flat Feet M/F Neuropathy M/F

Bunions M/F Diabetes M/F Hammertoe(s) M/F Stroke M/F

**Medications (Please list all or provide a list)  NONE  LIST PROVIDED**

**Name of Pharmacy: CVS Rite Aid Wal-Mart Wegmans Tops Walgreens**

 **Location of Pharmacy:**

** NONE ALLERGIES - (or check boxes below)**

Antibiotics Aspirin/Ibuprofen Betadine Iodine LATEX Lidocaine

Novocain Sulfa or Penicillin Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shoe Size**: **Height**: **Weight**: BP: Pulse:

 (To be taken at your appointment)

**Pharmacy Name**: **Location**:

I hereby authorize payments directly to Family Foot Care. I acknowledge I am aware of the HIPPA policies & practices and if necessary can obtain & sign a copy through your office. I also understand I am responsible for any portion of the bill, not covered by my insurance company and all co-payments and balances are due at the time of service.

Signed: Date:

**CHIEF COMPLAINT**:

**ONSET**: **DURATION**:

**OTHER COMPLAINTS**:

**PULSES**: **PT** LEFT RIGHT **DP** LEFT RIGHT

**VASCULAR**:

**INTEGUMENTARY**:

**ORTHOPEDIC**:

 **STANCE**:

 **GAIT**:

**NEUROLOGICAL**:

**Misc. Medical Notes:**