

# WELCOME TO FAMILY FOOT CARE ASSOCIATES

Please Print

Date: \_\_\_\_\_ Patient's Soc. Sec. # \_\_\_\_\_  
Patient's Legal Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Emergency No./Name \_\_\_\_\_  
Marital Status (circle one)    Single            Married            Widowed            Divorced            Separated  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Due to government regulations, the following questions are required:

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Nationality: \_\_\_\_\_  
(Circle One: Hispanic or Latino    Non Hispanic/Latino)  
Language: \_\_\_\_\_ Dominant Hand: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Spouse (Legal Name) \_\_\_\_\_ Employer \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Parents (if minor) Mother \_\_\_\_\_ Father \_\_\_\_\_  
Address \_\_\_\_\_  
Occupations \_\_\_\_\_  
Employers \_\_\_\_\_ Pharmacy \_\_\_\_\_  
Family Physician \_\_\_\_\_

Are you allergic to any of the following or is there any allergy our office should know about?

- |                                       |  |                                     |  |                                    |
|---------------------------------------|--|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Antihistamines    | <input type="checkbox"/> Mycins     | <input type="checkbox"/> Iodine          | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Caffeine        | <input type="checkbox"/> Sulfa     |
| <input type="checkbox"/> Cortisone    | <input type="checkbox"/> Adhesives/Tape    | <input type="checkbox"/> Keflex     | <input type="checkbox"/> Rubbing Alcohol | <input type="checkbox"/> Pollens   |
| <input type="checkbox"/> NO ALLERGIES | <input type="checkbox"/> Other _____       |                                     |  | <input type="checkbox"/> Latex     |

Are you pregnant? (Circle one)    yes    no

**Tobacco Use** - Smoke cigarettes: \_\_\_\_\_ Never \_\_\_\_\_ No \_\_\_\_\_ Yes

(If you never smoked please go to alcohol use question now)

Quit date: \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Approximately how many packs a day did you smoke? \_\_\_\_\_

Current smoker: Packs/day: \_\_\_\_\_ # of years: \_\_\_\_\_

Other tobacco: \_\_\_\_\_ Pipe \_\_\_\_\_ Cigar \_\_\_\_\_ Snuff \_\_\_\_\_ Chew

**Alcohol Use** - Do you drink alcohol? \_\_\_\_\_ No \_\_\_\_\_ Yes

# of drinks/week: \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor

**Drug Use** - Have you had any prescriptions filled for Vicodin, Percocet, Oxycontin or any Narcotic in the past 12 months?

(Circle One) Yes No If yes, how many \_\_\_\_\_

Do you use marijuana or recreational drugs: \_\_\_\_\_ No \_\_\_\_\_ Yes

Have you ever used needles to inject drugs: \_\_\_\_\_ No \_\_\_\_\_ Yes

Are you currently taking any medications? Please list them or give us a list that we may copy: \_\_\_\_\_

List any surgeries you have had in the last 5 years \_\_\_\_\_

(Continued on back)

Have you ever had any problems with anesthesia?  no  yes

Please list any back, leg, ankle or foot injuries that you have had \_\_\_\_\_

What is your foot/ankle problem? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_ Accident Date \_\_\_\_\_

Please list any previous treatment you have had for this problem \_\_\_\_\_

How did you find out about our office?

\_\_\_\_\_ Family Physician (name \_\_\_\_\_)  Family  Friend  Internet  Phone Book  Advertisement

**PERSONAL MEDICAL HISTORY:** Do you have now (current) or have you had (past) any of the following conditions:

\_\_\_\_\_ NONE

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Bleeding Disorder			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Cancer (Type _____)			
Cataracts			
Coronary Artery Disease			
Depression			
Diabetes (Type I)			
Diabetes (Type II)			
Diverticulosis			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Heart Attack			
Heart Problems			
Hepatitis - Type A			
Hepatitis - Type B			
Hepatitis - Type C			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Kidney Disease/Failure			
Leg Cramps			
Liver Disease			

