Kaplan Foot Care

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Welcome to my office!

PATIENT INFORMATION

First Name:	Middle Name:	Last Name:	
Date of Birth:		Age:	Sex: M F
Home Address:			
City:	State:	Zip Code:	Email:
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )
Preferred Method of Verbal Communication (Please circle one): Home Phone Work Phone Cell Phone		May we leave a message? Yes No	
Marital Status: S M D W		Driver License #:	
Occupation:		Employer:	
Employer Address:			
Primary Physician:		Phone: ( )	
Referred by:			

IN CASE OF EMERGENCY CONTACT

Last Name:	First Name:
Relationship:	Phone: ( )

PREFERRED PHARMACY

Name of Pharmacy:			
Address (or cross streets):	City:	State:	Zip Code:

INSURANCE INFORMATION

Name of Insured:	DOB:	Relationship:
Primary Insurance:	Phone: ( )	
Subscriber #:	Group#:	

Continue on the back

Name: _____

MEDICAL HISTORY

WHAT BROUGHT YOU TO SEE THE DOCTOR? (Please provide a brief description of the nature of the illness/injury.)

WHEN DID YOUR SYMPTOMS BEGIN?

WHAT TREATMENTS HAVE YOU TRIED?

WHAT OTHER FOOT/ANKLE/LEG PROBLEMS DO/DID YOU HAVE?

ALLERGIES: Do you have any allergies?

MEDICATIONS: What medications are you currently taking?

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems

	Yes	No		Yes	No
Heart Disease			Arthritis		
Heart Valve Replacement			Gout		
Heart Attack			Fibromyalgia		
Chest Pain			Osteoporosis		
Pacemaker			Leg Pain		
High Blood Pressure			Back Pain		
High Cholesterol			Weakness In Extremities		
Stroke			Numbness In Extremities		
Shortness Of Breath			Balance Problems		
Lung Disease			Dizziness		
Asthma			Headaches/Migraine		
Sleep Apnea			Changes/Loss of Vision		
Liver Disease			Stomach Ulcers		
Hepatitis			Tuberculosis		
Bleeding Disorder			HIV		
Clotting Disorder			Cancer *(What Type?)*		
Anemia			Thyroid Condition		
DVT (Blood Clot)			Pregnant		
Kidney Disease			Diabetes Type I ___ Type II ___		
Fractures *(When/Where?)*					
Joint Replacement *(Which?)*			Skin Condition *(What Kind?)*		
Other(S): *(Please specify)*					

FAMILY HISTORY

Please check if any of your family members have/had any of the following

	Yes	No		Yes	No
Bleeding Disorder			Gout		
Cancer			Arthritis		
Heart Trouble			Bunion		
High Cholesterol			Bunionette		
High Blood Pressure			Flat Feet		
Stroke			High Arched Feet		
Diabetes					
Other: *(Please specify)*					

SOCIAL HISTORY

	Yes	No	What kind,how much,& how often?
Do you smoke?			
Did you ever smoke?			
Caffeine? *(tea/coffee)*			
Alcohol use? *Currently using or used in the past*			
Illicit drugs?			
Do you exercise regularly			

PAST SURGICAL HISTORY

Procedure	Date	Surgeon	Complication
1.			
2.			
3.			
4.			

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

I certify that to the best of my knowledge that the information provided is true and accurate and I have disclosed all pertinent medical history.

SIGNATURE OF PATIENT (OR GUARDIAN): _____ DATE: _____