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Today's Date: / /

PATIENT INFORMATION FORM

Name		Preferred Name	
Gender ☐ M ☐ F	Birth Date / /		
Address		City	State
Zip Code -	Email		
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -	
Would you like to receive text messages for appointment reminders? ☐ Yes ☐ No			
What is your preferred contact method from our office? ☐ Home ☐ Cell ☐ Work ☐ Patient Portal			
Primary Language Spoken ☐ English ☐ Other:	Race/Ethnicity		
Marital Status ☐ S ☐ M ☐ D ☐ W ☐ DP			
Primary Care Physician	Phone ( ) -	Last Seen / /	
Pharmacy Name	Location		
Employer	Occupation		
Who is in charge of your medical management? ☐ Self ☐ Other:			
Emergency Contact Name	Relationship	Phone ( ) -	

INSURANCE INFORMATION

Primary Insurance: ☐ Aetna ☐ BCBS ☐ Cigna ☐ Humana ☐ Medicare ☐ Other:	
Secondary: ☐ Aetna ☐ BCBS ☐ Cigna ☐ Humana ☐ Medicare ☐ Other:	
Member's Name:	Member's Date of Birth: / /
If the patient is a minor (17 and under), name of guarantor or responsible party:	

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

Internet Search: ☐ Google using key words ______________________ ☐ Website ☐ Facebook / Social Media

Doctor Referral: ☐ Doctor ___________________________________

Referral: ☐ Friend/Patient Name __________________________________

Local Ad: ☐ Val Pak ☐ Lovin' Lemont Livin' ☐ Church

Other: ☐ Previous Patient ☐ Walk-in / Saw Sign ☐ Insurance Site

☐ ______________________________

Providing comprehensive, quality foot care for the entire family.

Allergies

☐ No known allergies
☐ No known drug allergies

I am able to take NSAIDs (Advil, Aleve, Aspirin, ibuprofen)
☐ Yes ☐ No: ____________

Allergy / Intolerance	Reaction	Severity
		mild mod severe
		mild mod severe
		mild mod severe
		mild mod severe

Medications

Please list all medications and supplements you are taking, or you may provide a complete separate list.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Past Medical & Surgical History

Condition	***Diagnosis Year***	***Condition***	***Diagnosis Year***	***Condition***	***Diagnosis Year***
☐ AIDS / HIV		☐ Frostbite		☐ Peripheral Neuropathy	
☐ Anemia		☐ GERD / Acid Reflux		☐ Peripheral Vascular Disease	
☐ Anxiety / Depression		☐ Gout		☐ Polio	
☐ Arthritis		☐ Headache/Migraine		☐ Pulmonary Embolism	
☐ Asthma		☐ Heart Disease		☐ Raynaud's Disease	
☐ Back Pain / Sciatica		☐ Hepatitis A / B / C		☐ Rheumatoid Arthritis	
☐ Bleeding Disorder		☐ Hernia		☐ Seizures / Epilepsy	
☐ Blood Clots / DVT		☐ Hypertension (Blood Pressure)		☐ Stroke / CVA	
☐ Cancer		☐ Kidney Disease		☐ Substance Abuse	
☐ Diabetes - Type 1 / 2		☐ Leg / Foot Ulcers		☐ Thyroid Problems	
☐ Dialysis		☐ Liver Disease		☐ Tuberculosis	
☐ Dyslipidemia (High Cholesterol)		☐ Lung Disease		☐ Varicose Veins	
☐ Environmental allergies		☐ Organ Transplant		☐ Other:	
☐ Fibromyalgia		☐ Osteoporosis		☐ Other:	
☐ Foot Deformity		☐ Pacemaker / Defibrillator		☐ Other:	

Surgery	***Year***	***Surgery***	***Year***	***Other Surgery***	***Year***
☐ Anesthesia problems		☐ Leg stent / bypass R / L		☐ Cataracts	
☐ Heart bypass / stent		☐ Vein Procedure		☐	
☐ Hip Replacement R / L		☐ Foot/Ankle		☐	
☐ Knee replacement R / L		☐ Foot/Ankle		☐	

Other Medical History

Height: ______ ' ______ "   Weight: __________ lbs   Shoe size: *Right* __________ *Left* __________

Major medical conditions in your family:

- ☐ Unknown
- ☐ Mother: ______________________________
- ☐ Father: ______________________________
- ☐ Sibling: ______________________________
- ☐ Other: ______________________________

Cigarette Smoking Use: ☐ Never ☐ Former smoker for _______ yrs ☐ Current smoker: _______ yrs _______ PPD

Chewing Tobacco Use: ☐ Never ☐ Former user for _______ yrs ☐ Current user: _______ yrs Type:

Vaping/E-cigarette Use: ☐ Never ☐ Former user for _______ yrs ☐ Current user: _______ yrs

Alcohol intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit drug use: ☐ None ☐ ______________ ☐ Medical marijuana

Special diet: ☐ No ☐ Yes : ______________

Activity level at work: ☐ Sitting ☐ Standing ☐ Walking ☐ Driving

Exercise level: ☐ Minimal ☐ Occasional ☐ Moderate ☐ Heavy

Sporting activities: ______________________________

Difficulty walking or climbing stairs? ☐ No ☐ Yes

Are you able to care for yourself? ☐ No ☐ Yes

Legally blind in one or both eyes? ☐ No ☐ Yes

Reason For My Visit Today

Please list up to 2 conditions, with #1 being the most important.

1) **Reason for my visit:** ______________ **Location:** ______________

How long have you had this: ________ days wks mos yrs **Severity**: mild moderate severe. Pain levels: + / 10

Symptoms: ______________________________

What makes it feel worse? ______________________________

How often is this bothering you? ______________ **Possible cause:** ______________

Any past treatments: ______________________________

Any treatment goals: ______________________________

2) **Reason for my visit:** ______________ **Location:** ______________

How long have you had this: ________ days wks mos yrs **Severity**: mild moderate severe. Pain levels: + / 10

Symptoms: ______________________________

What makes it feel worse? ______________________________

How often is this bothering you? ______________ **Possible cause:** ______________

Any past treatments: ______________________________

Any treatment goals: ______________________________