

Family Foot & Ankle Specialists, LLC

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www.stopfootpainfast.com

WE ARE VERY PLEASED TO HAVE YOU WITH US!

Please answer the following questions to help us become acquainted.

Date _____ Referred by _____

Name _____ Age _____ Birthdate _____

SS# _____ Driver's Lic # _____ Sex: M F Marital Status: M S D W

Address _____ City _____ State _____ Zip _____

Home # () _____ Business # () _____ Cell # () _____

E-Mail Address _____ Employer _____

Address _____

Name of Spouse or Parent (if minor) _____

Name of Insurance _____ Name of Insured _____

Insured's S. S. # _____ Insured Date of Birth _____

FOR EMERGENCIES, PLEASE SUPPLY:

Spouse's Employer _____ Spouse's Business Phone () _____

Family Doctor's Name & Address _____

Date last seen by family physician _____

Have you had previous foot treatment? _____ When? _____

What is your foot problem? _____

Height _____ Weight _____ Shoe Size _____ Width _____

FAMILY HISTORY

	YES	NO
Does heart trouble run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Does diabetes run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Does high blood pressure run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Does epilepsy run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Do bleeding disorders run in your family?	<input type="checkbox"/>	<input type="checkbox"/>
Do ulcers run in your family?	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL HISTORY

If you have, or have had, any of the following, please check:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Polio
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis or Gout
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Urinary Disorders	<input type="checkbox"/> Nerve Disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Fractures (broken bones) Where & When _____	

ALLERGIES Have you ever experienced any ill effects from the following:

- Novocaine
- Sulfa
- Aspirin
- Penicillin
- Iodine (shellfish)
- Antibiotics (type) _____
- Codeine
- Adhesive Tape

Allergies to any other medication (name?) _____

Type of reaction (nausea, hives, difficulty in breathing, etc)? _____

MEDICATIONS: What medications do you take or have you taken in the last six months?

- Blood pressure medication Name _____
- Medicine for your blood Name _____
- Heart medicine Name _____
- Diabetes medicine Name _____
- Vitamins Name _____
- Thyroid medicine Name _____
- Circulation medicine Name _____
- Nerve/Tranquilizer medicine Name _____
- Other medicine Name _____

SURGICAL HISTORY

YES **NO**

- Have you ever had any operations?.....
- Have you ever had any operations on your feet?

If yes, please list the type(s) of surgery and the date(s) performed _____

I hereby give permission to Dr. Wishnie, Dr. Shah, Dr. Kosofsky and Dr. Waters to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my ankle/foot condition.

Date _____ Signature _____

(If patient is a minor, parent or guardian must sign)



Over 70% of our patients bring in their children. Children have various foot problems including plantar warts and flat feet. Did you know most foot problems are hereditary? It is always good to have your child looked at. An ounce of prevention is worth a pound of cure.

I would like my family members checked for any foot and/or ankle problems.

Don't miss out!