

Medical History and Patient Information

PATIENT INFORMATION

Patient's Name _____ **Telephone Home** _____

Home Address _____ Telephone Work _____

City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Social Security # _____ Sex M / F

Marital Status S M D SEP W

Patient Employed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____

Spouse's Name _____ Business Phone _____

Spouse Employed By _____ Business Address _____

City _____ State _____ Zip Code _____

Referral: How were you referred to our office? _____

Pharmacy: What pharmacy do you use? _____ Phone _____

Who may we contact in case of an Emergency? _____ Phone _____

INSURANCE, MEDICARE INFORMATION

Company or Program Insured SS#/ID# Group # DOB (Insured)

I will be paying today by CASH _____ CHECK _____ CREDIT CARD _____

I hereby give my permission to Dr. Miller to administer Treatment and to perform such procedures as may be necessary in the Diagnosis and/or Treatment of my foot condition.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

PLEASE PROVIDE THE ADMINISTRATOR A COPY OF ALL INSURANCE CARDS AND YOUR PHOTO IDENTIFICATION.

Patient's Name _____

MEDICAL INFORMATION GENERAL

Family Physician _____ Telephone _____ Date last Seen _____

What are your present foot problems? _____

How long have you been bothered by this problem(s) _____ Did it start: suddenly or gradually

On a scale of 1 to 10, (10 being the worst) how bad is the pain 1 2 3 4 5 6 7 8 9 10

What kind of daily activities aggravate your foot condition: _____

What kind of treatments have you done for this condition at home? _____

Have you seen a Doctor for this condition? Yes or No Was the Doctor a Podiatrist? Yes or No

Name and telephone number of previous doctor(s) who treated your foot condition?

On the diagram below, please mark the place(s) where you are experiencing pain in you feet:

Regarding the place(s) you marked above, describe the pain you are experience, for instance, mild, moderate, severe. throbbing, burning, stabbing, etc., and the time of day it occurs:

MEDICAL HISTORY

Patient's Name _____

Height _____ Weight _____ Shoe Size R _____ L _____

Date of last physical exam: _____

Doctor and Telephone Number: _____

Social History

Are you on a Special Diet? _____

Do you Smoke? _____ Yes _____ No # of packs per day _____ # of years _____

Previously Smoked? _____ Yes _____ No # of packs per day _____ # of years _____

Do you drink? _____ Yes _____ No

If yes, how often? _____ 1-2 per week _____ 1-2 per day _____ more than 2 daily

WOMEN: Number of Children _____ Are you pregnant _____ Yes _____ No
Number of months pregnant _____

Diabetes/Circulation

Are you under active care for Diabetes and or circulation problems? _____ Yes _____ NO

If so, Doctors name _____ Telephone Number _____

Date Last Seen by the above doctor _____

Insulin dependent Diabetic? _____ Yes _____ No Diet Controlled? _____ Yes _____ No

of years being diabetic _____ Average blood sugar range _____

Allergies

_____ Penicillin _____ Novocaine _____ Codeine _____ Local Anesthesia

_____ Sulfa drugs _____ Codeine _____ Aspirin _____ Cortisone

_____ Mercurials _____ Any Antibiotic _____ Tape _____ **No known allergies**

_____ Other _____

FAMILY MEDICAL HISTORY

Mother	_____ Living	_____ Deceased	Cause of Death _____
Father	_____ Living	_____ Deceased	Cause of Death _____
Brother	_____ Living	_____ Deceased	Cause of Death _____
Sister	_____ Living	_____ Deceased	Cause of Death _____

Has anyone in you family ever been treated for?:

You Father Mother Brother Sister Children Relatives

Arthritis

Cancer

Diabetes

Foot problems

Gout

Neuromuscular disease

Peripheral vascular disease

Tuberculosis

Varicose veins

Heart disease

Bleeding disorder

Stroke

Asthma

Other Illnesses or Problems

Patient's Name _____

Review of Systems (ROS)

Please check each item that applies to you.

<u>Constitutional (general):</u>	Comments	<u>Eyes, Ears, Nose, Throat</u>	Comments
<input type="checkbox"/> Weight loss/10+	_____	<input type="checkbox"/> Impaired sight	_____
<input type="checkbox"/> Weight Gain+15	_____	<input type="checkbox"/> Eye disease	_____
<input type="checkbox"/> Fatigue	_____	<input type="checkbox"/> Eye pain	_____
<input type="checkbox"/> Nausea	_____	<input type="checkbox"/> Vision problems	_____
<input type="checkbox"/> Fever	_____	<input type="checkbox"/> Eye infections	_____
<input type="checkbox"/> Chills	_____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Hearing loss	_____
		<input type="checkbox"/> Ringing in ears	_____
<u>Respiratory:</u>		<input type="checkbox"/> Ear infections	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Dizzy spells	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Fainting Spells	_____
<input type="checkbox"/> Pneumonia/Pleurisy	_____	<input type="checkbox"/> Nose Bleeds	_____
<input type="checkbox"/> Shortness/breath	_____	<input type="checkbox"/> Breathing Difficulties	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Sinus problems	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Sore throat	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Hoarseness	_____
<input type="checkbox"/> C.O.P.D.	_____	<input type="checkbox"/> Speech Difficulties	_____
<input type="checkbox"/> History smoking	_____	<input type="checkbox"/> Dental problems	_____
<input type="checkbox"/> Use of Oxygen	_____	<input type="checkbox"/> Infected teeth	_____
<input type="checkbox"/> Limited exercise	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> tolerance	_____		
<input type="checkbox"/> Other	_____	<u>Cardiovascular</u>	
<u>Gastrointestinal:</u>		<input type="checkbox"/> Chest pain	_____
<input type="checkbox"/> Loss of appetite	_____	<input type="checkbox"/> Heart attack	_____
<input type="checkbox"/> Excessive hunger	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Excessive thirst	_____	<input type="checkbox"/> Open Heart Surgery	_____
<input type="checkbox"/> Heart burn	_____	<input type="checkbox"/> Heart murmur	_____
<input type="checkbox"/> Peptic ulcer	_____	<input type="checkbox"/> Swelling ankles/feet	_____
<input type="checkbox"/> Persistent nausea	_____	<input type="checkbox"/> Palpitations	_____
<input type="checkbox"/> Difficulty swallowing	_____	<input type="checkbox"/> Irregular beat/pulse	_____
<input type="checkbox"/> Vomiting	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Abdominal pain	_____	<input type="checkbox"/> Mitral valve prolapse	_____
<input type="checkbox"/> Gallbladder problem	_____	<input type="checkbox"/> Angioplasty	_____
<input type="checkbox"/> Liver problems	_____	<input type="checkbox"/> Artificial heart valve	_____
<input type="checkbox"/> Jaundice	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> Circulation disorder	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Hepatitis C	_____	<input type="checkbox"/> Leg pain/walking	_____
<input type="checkbox"/> Cirrhosis	_____	<input type="checkbox"/> Leg pain/rest	_____
<input type="checkbox"/> Diarrhea	_____	<input type="checkbox"/> Tiredness in legs	_____
<input type="checkbox"/> Diverticulosis	_____	<input type="checkbox"/> Varicose veins	_____
		<input type="checkbox"/> Phlebitis	_____
		<input type="checkbox"/> Blocked arteries	_____

Gastrointestinal cont.:

_____ Crohn's/colitis _____
 _____ Bloody or black stool _____
 _____ Heartburn/reflux _____
 _____ Other _____

Cardiovascular cont.:

_____ Cold, numb feet _____
 _____ Angina New onset _____
 _____ Angina + intensity _____
 _____ Angina + occurrence _____

Bladder, Kidney

_____ Frequent urination _____
 _____ Bladder infections _____
 _____ Blood in urine _____
 _____ Kidney stone _____
 _____ Renal failure _____
 _____ Swelling feet _____

Hematologic (Blood Disorders)

_____ Anemia _____
 _____ Bruise easily _____
 _____ Cancer _____
 _____ Blood transfusion _____
 _____ Sickle cell disease _____
 _____ Take Coumadin _____

Endocrine

_____ Diabetes _____
 _____ Thyroid disease _____
 _____ Osteoporosis _____
 _____ Other _____

Neurological (Nervous)

_____ Seizures _____
 _____ Tremor/hands shake _____
 _____ Headaches/frequent _____
 _____ Stroke _____
 _____ Change in memory _____
 _____ Trouble with balance _____

Bone and Joint

_____ Arthritis/Rheumatism _____
 _____ Back pain-recurrent _____
 _____ Gout _____
 _____ Osteoporosis _____
 _____ Ostoarthritis _____
 _____ Rheumatoid arthritis _____
 _____ Artificial joints _____
 _____ Severe arthritis of TMJ _____

_____ Spine disease _____
 _____ Sciatica _____
 _____ Numbness _____
 _____ Muscle weakness _____
 _____ Polio _____
 _____ Change in sensation _____

Psychiatric:

_____ Sleeping difficulty _____
 _____ Depression _____
 _____ Nervousness _____
 _____ Agitation _____
 _____ Memory loss _____
 _____ Moodiness _____
 _____ Phobias _____
 _____ Mental Illness _____
 _____ Concentration difficul. _____
 _____ Suicidal thoughts _____
 _____ Feelings of worthlessness _____

Skin

_____ Rashes _____
 _____ Hives _____
 _____ Psoriasis _____
 _____ Eczema _____
 _____ Skin cancer _____
 _____ New growths _____
 _____ Color change (mole) _____
 _____ Thick scar or keloid _____

Immunology

_____ HIV _____
 _____ Weak immune system _____
 _____ Chronic fatigue _____

Childhood Illnesses

Male:

_____ Rheumatic fever _____
_____ Scarlet fever _____
_____ Chicken pox _____
_____ Mumps _____
_____ Measles _____
_____ Herpes _____
_____ Other _____

_____ Sexual transmissive disease _____
_____ Prostate cancer _____

Female:

_____ Breast cancer _____
_____ Ovarian cancer _____
_____ Oral contraceptives _____
_____ Sexual trasmissive disease _____
