FAMILY FOOT & ANKLE CARE
801 Volvo Parkway, Ste. 130
Chesapeake, VA 23320
www.familyfootcareva.com

NAME:_____ **DATE OF BIRTH:**_____/_____/_____

EMAIL ADDRESS:_____ **SSN:** _____ - _____ - _____

ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL:**_____

DO YOU PREFER TO BE CALLED AT HOME OR ANOTHER NUMBER? _____

AGE:_____ **SEX: M / F** **WEIGHT:**_____ **HEIGHT:**_____ **SHOE SIZE:**_____

ARE YOU? (CIRCLE ONE): **SINGLE** **MARRIED** **WIDOWED** **SEPARATED** **DIVORCED**

EMPLOYER:_____ **OCCUPATION:**_____

EMPLOYER'S ADDRESS:_____

PRIMARY INSURANCE CO.:_____ **ID#:**_____ **GRP:**_____

NAME OF SUBSCRIBER:_____ **DOB:**_____/_____/_____ **SSN:**_____ - _____ - _____

SECONDARY INSURANCE CO.:_____ **ID#:**_____ **GRP:**_____

NAME OF SUBSCRIBER:_____ **DOB:**_____/_____/_____ **SSN:**_____ - _____ - _____

EMERGENCY CONTACT NAME:_____ **PHONE #:**_____

HAVE YOU EVER SEEN A PODIATRIST OR ORTHOPEDIST FOR A FOOT OR ANKLE CONDITION? YES / NO

WAS IT IN THE LAST 65 DAYS? YES / NO

HAVE YOU HAD FOOT OR ANKLE SURGERY IN THE LAST 2 YRS? YES / NO IF YES, WHO, WHERE, AND WHEN?

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN NAME:_____ **PHONE:**_____

PREFERRED PHARMACY AND STREET LOCATION:_____

REASON FOR VISIT:_____ **HOW LONG?**_____

I hereby give my permission to Family Foot Care Centers, P.C. to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition, and authorize , to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with other treating physicians. I understand that I am responsible for any co-pays and/or deductibles that my insurance requires in order to receive treatment and care. Furthermore, I assign all payments of medical benefits provided by my insurance company for medical/surgical care to Family Foot Care Centers, P.C./ Dr. Marc Fink, D.P.M.

SIGNATURE: _____ **DATE:**_____
(PATIENT OR THE PERSON AUTHORIZED TO CONSENT FOR PATIENT)

PRINT NAME:_____ **RELATIONSHIP TO PATIENT:**_____

MEDICAL INFORMATION

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

MAJOR DISEASES

[ ] DIABETES: A1C LEVEL:_____ DRAWN ON:___/___/___
[ ] HIGH BLOOD PRESSURE
[ ] LOW BLOOD PRESSURE
[ ] ANGINA
[ ] ARRHYTHMIA
[ ] HEART MURMUR
[ ] MITRAL VALVE PROLAPSE
[ ] STROKE
[ ] HIGH CHOLESTEROL
[ ] CANCER
[ ] _____

HEENT

[ ] HEADACHES
[ ] GLAUCOMA
[ ] HEARING PROBLEMS
[ ] _____

ARTHRITIS

[ ] OSTEOARTHRITIS
[ ] RHEUMATOID ARTHRITIS
[ ] GOUT
[ ] LUPUS
[ ] _____

VASCULAR

[ ] ANEMIA
[ ] PROLONGED BLEEDING
[ ] PACEMAKER
[ ] POOR CIRCULATION
[ ] LEG PAIN WHEN WALKING
[ ] VARICOSE VEINS
[ ] BLOOD CLOTS (FROM SURGERY OR OTHERWISE)

RESPIRATORY

[ ] COPD
[ ] ASTHMA
[ ] TUBERCULOSIS
[ ] EMPHYSEMA

GASTROINTESTINAL

[ ] ULCERS
[ ] ACID REFLUX (GERD)
[ ] STOMACH PROBLEMS
[ ] HIATAL HERNIA
[ ] GI OR RECTAL BLEED
[ ] IRRITABLE BOWEL SYNDROME
[ ] CROHNS DISEASE
[ ] _____

PSYCHOLOGICAL

[ ] ANXIETY
[ ] DEPRESSION
[ ] PSYCHIATRIC CARE
[ ] DRUG DEPENDENCE
[ ] ALCOHOL DEPENDENCE
[ ] _____

MISCELLANEOUS

[ ] EPILEPSY
[ ] THYROID DISEASE
[ ] MUSCLE DISEASE
[ ] KIDNEY DISEASE
[ ] BLADDER PROBLEMS
[ ] PROSTATE PROBLEMS
[ ] HIV/AIDS
[ ] HEPATITIS
[ ] VENEREAL DISEASE
[ ] LIVER DISEASE
[ ] SEIZURES

DERMATOLOGY

[ ] RASH
[ ] SKIN ULCERS
[ ] FUNGAL NAILS
[ ] PHEBITIS
[ ] CORNS / CALLOUSE

OTHER MEDICAL PROBLEMS

[ ] PROBLEMS UNDER ANESTHESIA
[ ] _____

FAMILY HISTORY: WHAT AND WHO? (CHECK OFF ILLNESS AND CIRCLE RELATIVE)

MOTHER FATHER BROTHER SISTER GRANDFATHER GRANDMOTHER

[ ] HEART DISEASE [ ] DIABETES [ ] HIGH BLOOD PRESSURE [ ] CANCER

[ ] OTHER:_____

DO YOU SMOKE? YES / NO IF YES, HOW MANY YEARS?_____ HOW MANY PACKS PER DAY?_____

DID YOU QUIT? YES / NO IF YES, WHEN? _____

DO YOU DRINK? YES / NO IF YES: SOCIALLY/ DAILY

FEMALE: ARE YOU PREGNANT? YES / NO

LIST ALL THE SURGERIES AND HOSPITALIZATIONS YOU HAVE HAD:

_____

_____

_____

LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS WITH THE DOSAGES THAT YOU ARE CURRENTLY TAKING:

_____ _____**mg.** _____**mg.**

_____**mg.** _____**mg.**

_____**mg.** _____**mg.**

_____**mg.** _____**mg.**

(NEED MORE SPACE FOR MEDICATIONS? TURN TO THE BACK OF THE PAGE.)

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

[ ] LATEX [ ] LIOCAINE [ ] IODINE [ ] PENICILLIN [ ] CODEINE [ ] ASPIRIN [ ] ADHESIVE TAPE

[ ] TETANUS [ ] SULFA DRUGS [ ] OTHER _____ [ ] NO KNOWN ALERGIES

TYPE OF ALLERGIC REACTION:_____ [ ] SEVERE [ ] MODERATE [ ] MILD