WELCOME TO
NEW HAVEN FAMILY FOOT CARE AND SURGERY

Last Name_____ **First Name** _____ **Sex: M**____ **F**___

Address_____ **City**_____**State**_____**Zip**____

SS#_____ **Age** _____ **Marital Status: S**____ **M**____ **W**____ **D**____ **SEP**____

Date of Birth _____ **Home Phone** _____ **Work Phone** _____

Patient's Employer_____ **Position** _____

Employer's Address_____ **Work #**_____

If patient is a student, name of school _____

Spouse's Name_____ **Spouse's Employer** _____

Primary Physician_____**Phone #**_____

Other Physician_____**Phone#**_____

How did you hear about our office?_____

Primary Insurance _____ **ID #** _____ **Group #** _____

Secondary Insurance _____ **ID #** _____ **Group#** _____

EMERGENCY CONTACT

Name_____**Relationship**_____**Phone** _____

Address (if different than above)_____

Employer _____ **Employer Address**_____

Benefits to Physician/Statement of Financial Responsiblity
I hearby authorize payments to the physician of all medical/surgical benefits. I understand and agree that I am responsible for the balance of my bill not paid by my insurance company for any professional services rendered. I also understand that it is my responsibility to notify the office of any changes in my health status, primary care physician, and my insurance status.

Release of information
I hearby authorize the release of my medical information to my insurance carrier, my primary care physician, and any consulting physician as part of the normal process in the delivery of health care. This release of information may include record of communicable diseases such as syphilis, gonorrhea, hepatitis, HIV, and AIDS.

I UNDERSTAND ALL OF THE ABOVE AND HEARBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
DATE **SIGNATURE**

Personal Medical Information

What is the reason for your visit today? _____
_____
_____

Any past problems with your feet or ankles, including any surgical procedures? If yes, please describe. _____
_____

Have you ever seen a podiatrist before? _____ If yes, who was the podiatrist? _____
What is your shoe size? _____ Your current weight? _____ Your current height_____

GENERAL HEALTH INFORMATION

Do you have Diabetes? YES_____ NO_____ If yes, do you take insulin? YES___ NO_____
How long?_____

Have you had any operations? If yes, describe. _____
_____

Are you under a physicians care? YES _____ NO _____ For what condition are you being treated? _____

Date you last saw your primary doctor? _____ May we contact your doctor about your health? YES _____ NO_____

What pharmacy do you use? _____
Town and telephone number of your pharmacy _____

What medications (include non prescription) do you use? _____
_____

Please check any of the following medical problems that apply to you:

Asthma _____ Anemia _____ Arthritis _____ Blood Clots _____ Cancer _____ Diabetes _____
yed Healing _____ Circulation problems _____ Heart Condition _____ Hepatitis _____
Gout_____ Heart Attack _____ High Blood Pressure _____ HIV _____ Hormones _____
Infections _____ Kidney Dysfunction _____ Liver Problems _____ Neurological Disorder _____
Parkinson's Disease _____ Rheumatic Fever _____ Skin Problems _____ Stomach Ulcer _____
Stroke _____ Tuberculosis _____ Unexplained weight loss/gain_____

PODIATRIC HISTORY

Check if there is a family (blood relative) history of?

Heart Disease _____ Arthritis _____ Bleeding Disorder _____ Bunions _____ Diabetes _____
Circulation Problems _____ Flat feet _____ Hammer toes _____ Neurological Disorder _____
Stroke _____

Check any of the following foot problems that apply to you:

Ankle Pain _____ Athletes Foot _____ Bunions _____ Corns/Calluses _____ Flat Feet _____

Fungus _____ Hammertoes _____ Heel pain _____ Ingrown toenails ____ Warts _____

Numbness/Cramps in legs or feet _____ Swollen feet _____ Tired feet _____

Other _____

Are you allergic or sensitive to any of the following?

Adhesive tape _____ Penicillin _____ Coumadin _____ Aspirin _____ Latex _____

Codeine_____ Iodine _____ Local Anesthetics _____ Novacaine _____ Seafood _____

Sulfa_____ Other Medications or foods _____

Do you have any artificial joint (hips, knees, etc.)? YES___ NO____ If yes, please describe.
_____

Do you have a Heart Valve Implant? YES _____ NO _____

Do you smoke? YES _____ NO _____ If yes, how many packs per day_____ Number of years smoking_____
Previously smoked? YES_____ NO_____ How long ago did you quit?_____

Do you drink alcohol or beer? YES ____ NO ____ Light Usage___ Moderate(1-2 per day) ____
Heavy (more than 2 per day) _____

Occupation: _____

Describe your routine at work:
Sit at job _____ Stand at job _____ Stand and walk at job _____ Retired_____

We thank you for taking the time to complete this medical history form. This helps us to make the best decisions concerning your medical care.

I understand all of the above and hereby state that the information is correct and accurate to the best of my knowledge.

_____ _____
Patient Signature/ Legal Guardian **Date**