DATE_____ HOME PHONE ( )_____

NAME_____ AGE_____ DATE OF BIRTH_____

ADDRESS_____

MARITAL STATUS (Circle) SINGLE MARRIED WIDOWED OTHER

EMPLOYMENT: YOURS
COMPANY_____
PHONE ( )_____

SPOUSE_____
COMPANY_____
PHONE ( )_____

PRIMARY PHYSICIAN_____ PHONE ( )_____
DRUG STORE_____ PHONE ( )_____
WHICH FOOT HURTS?(Circle) LEFT RIGHT BOTH
MAIN COMPLAINT_____
HEIGHT_____ WEIGHT_____ SHOE SIZE_____

PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST

MEDICAL HISTORY, PLEASE INDICATE WITH AN "X"

_____HEART TROUBLE
_____HIGH BLOOD PRESSURE
_____TUBERCULOSIS
_____KIDNEY OR LIVER CONDITION
_____ASTHMA
_____DIABETES
_____SINUS PROBLEM
_____EXCESSIVE BLEEDING
_____ALLERGIES
_____CIRCULATION PROBLEM

_____REACTION TO ANY DRUGS
_____ALLERGIC TO: PENICILLIN, NOVACAINE, ASPIRIN; CODEINE
_____ANEMIA
_____EAR OR EYE TROUBLE
_____RHEUMATIC FEVER
_____ARTHRITIS
_____CORTISONE TREATMENT
_____HORMONE THERAPY
_____BIRTH CONTROL PILLS

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO
IF YES, WHY?_____
LIST CURRENT MEDICATIONS_____
_____
HAVE YOU EVER BEEN HOSPITALIZED? YES NO IF YES, WHY?_____
_____
ANY PREVIOUS FOOT CARE? YES NO IF YES, WHEN?_____
WOMEN - ARE YOU PREGNANT? NO YES DUE DATE?_____

Thank you for filling out this form. It will help us in giving you the best Podiatric Medical care. With my permission, based on her examination, I authorize Dr. Lehman to perform tests and suggest a treatment plan.

SIGNATURE_____