DUBUQUE PODIATRY – PATIENT INFORMATION

Date ________________________
Name ______________________ (First) ________________________________ (Middle) ____________________________________ (Last) Sex: (F) (M)

Birth Date __________________________ Age ___________ SS#___________________________________ Marital Status (S) (M) (W) (D)
Address ____ Cell Ph # (________) ______________________
City __________________________________ State ___________ Zip ___________________ Phone # (________) ______________________
Email Address ____
Place of Employment ____ Phone # (________) ______________________
Emergency Contact ____ Phone # (________) ______________________
Referred by ____

If Patient is a Minor, please complete this section

Father's Name __________________ (First) ________________________ (Middle) _____________________ (Last) D.O.B. __________ SS# ______________________

Address ____ City ______________________ State ___________ Zip _____________

Father's Employer ____ Phone # (________)_____________________

Mother's Name _________________ (First) ________________________ (Middle) _____________________ (Last) D.O.B. __________ SS# ______________________

Address ____ City ______________________ State ___________ Zip _____________

Mother's Employer ____ Phone # (________)_____________________

If Patient is Married, please complete this section

Spouse's Name _________________ (First) ________________________ (Middle) _____________________ (Last) D.O.B. __________ SS# ______________________

Address ____ City ______________________ State ___________ Zip _____________

Primary Insurance

Ins. Name ____ Subscriber _______________________________________
ID# ____ Group # ________________________ Co-Pay ___________ Effect. Date _____________
Address ____ City ______________________ State ___________ Zip _____________

Secondary Insurance

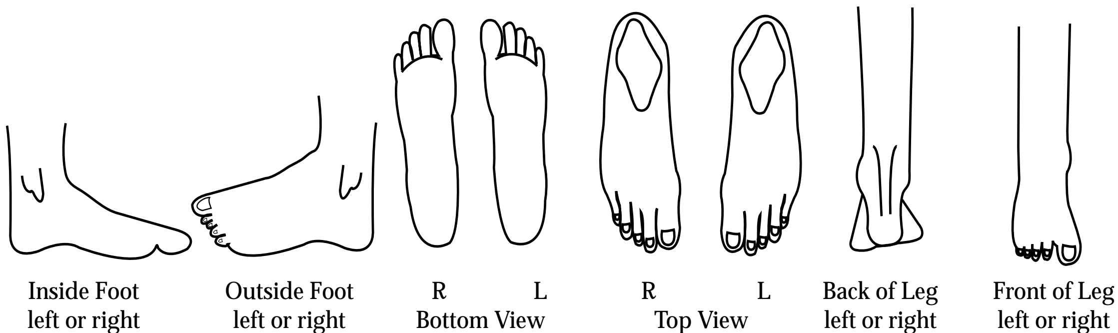
Ins. Name ____ Subscriber _______________________________________
ID# ____ Group # ________________________ Co-Pay ___________ Effect. Date _____________
Address ____ City ______________________ State ___________ Zip _____________
Additional Insurance ____

PLEASE SIGN

I authorize Dubuque Podiatry P.C. to treat my and my dependents foot/ankle problem. I authorize the release of Medical information necessary to process this claim. I authorize the payment of medical benefits to Dubuque Podiatry. I understand that I am responsible for all costs of treatment.

X____ Relationship __________________________________

Please mark with an "X" where your pain is located on your feet:



Race
- ◯ Caucasian
- ◯ American Indian
- ◯ African American
- ◯ Hawaiian/Pacific Islander
- ◯ Asian
- ◯ Other: _________________

Ethnicity
- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Latino

Language: _________________

Foot Problem or Symptoms: ____________________
(Please describe in your own words)
____
____

How long have you had this problem? ________Days ________Weeks ________Months ________Years

Medical History

	Yes	No
1. Heart Problems		
☐ Mitral Valve Prolapse ☐ Heart Attack		
☐ Stroke ☐ Other		
2. Diabetes	☐	☐
If Yes-How Do You Control Your Diabetes		
Diet Pills Insulin		
Any member of family that had diabetes?	☐	☐
If so, how related? ____________		
3. Lung Problems:		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Other	☐	☐
4. Liver Problems:		
Hepatitis	☐	☐
Jaundice	☐	☐
Other	☐	☐
5. Circulation Problems:		
Varicose Veins	☐	☐
Phlebitis (Blood Clots)	☐	☐
Peripheral Vascular Disease	☐	☐
Poor Circulation	☐	☐

	Yes	No
1. High Blood Pressure	☐	☐
2. Low Blood Pressure	☐	☐
3. Ulcers	☐	☐
4. Arthritis	☐	☐
5. Gout	☐	☐
6. High Cholesterol Levels	☐	☐
7. Cancer (Type____________)	☐	☐
8. Epilepsy or Seizure Disorder	☐	☐
9. Kidney Problems	☐	☐
10. Thyroid Condition	☐	☐
11. Glaucoma	☐	☐
12. History of Rheumatic Fever	☐	☐
13. Artificial Joint Replacement	☐	☐
Premedication Necessary?	☐	☐
14. Immune System Disorders (Aids, HIV, ARC)	☐	☐
15. Venereal Disease	☐	☐
16. Anemia	☐	☐
17. Prone to Infection	☐	☐
18. Scar Problems	☐	☐
19. Bleeding Disorders	☐	☐

Shoe Size ______ Height ______ Weight ______

Pharmacy Name: ____________________
Physician Name: ____________________
Date of Last Visit: ____________________

	Yes	No
Any Other Medical Problems?	☐	☐
If Yes-Please List ____________		
Past or Present Surgeries?	☐	☐
If Yes-Please List ____________		
Are you presently taking any medication?	☐	☐

If Yes-Please list or provide a list:
____

Do you have any medication allergies? ____________________

Allergies to ☐ adhesive tape or ☐ metals

	Yes	No	
Do You Smoke?	☐	☐	If Yes-How Much ______ How Many Years______
Do You Consume Alcoholic Beverages?	☐	☐	If Yes-How Much Per Day/Week ____________
Do You Consume Caffeinated Beverages?	☐	☐	If Yes-How Much Per Day/Week ____________

How many hours are you on your feet a day? ____________________

Outside/Athletic Activities? ____________________