BATAVIA FOOT CARE CENTER
CONFIDENTIAL PATIENT INFORMATION FORM

Date:______________________ (YOU MUST BE 18 YEARS OR OLDER TO SIGN)

____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

SOC SEC NUMBER_________________________________AGE_______________DATE OF BIRTH_________________

SINGLE MARRIED WIDOWED DIVORCED____
(NAME OF SPOUSE OR PARENT IF MINOR) SOC SEC NUMBER DATE OF BIRTH

STREET ADDRESS____________________________________ CITY_____________________ STATE_____ ZIP________

PHONE NUMBERS: HOME______________________ CELL_______________________WORK______________________

EMAIL ADDRESS____________________________________HEIGHT______WEIGHT_______SHOE SIZE________WIDTH______

____
OCCUPATION – PATIENT NAME & ADDRESS OF EMPLOYER

____
OCCUPATION – SPOUSE OR PARENT NAME & ADDRESS OF EMPLOYER

FAMILY PHYSICIAN_________________________________ADDRESS________________________LAST SEEN______________

YOUR PHARMACY____ADDRESS____

FORMER PODIATRIST____________________________________LAST SEEN____

WHAT IS YOUR CHIEF FOOT COMPLAINT?____
DO YOU HAVE DIABETES? YES NO DATE OF LAST BLOOD SUGAR_____________________________________
HAVE YOU HAD ANY OPERATIONS? (PLS GIVE DATE & TYPE OF OPERATION)___________________________
____

DO YOU TAKE ANY MEDICINES REGULARLY? (IF SO PLEASE LIST)__________________________________
____
____

IS THERE ANY FAMILY HISTORY OF: (PLEASE CIRCLE THOSE THAT APPLY & SPECIFY WHICH RELATIVE HAS THE STATED DISEASE)

DIABETES	**CANCER**	**HEART DISEASE**	**HIGH BLOOD PRESSURE**	**NONE**
Mother: Living / Deceased	Mother: Living / Deceased	Mother: Living / Deceased	Mother: Living / Deceased	
Father: Living / Deceased	Father: Living / Deceased	Father: Living / Deceased	Father: Living / Deceased	
Relative:____________	Relative:____________	Relative:____________	Relative:____________	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE THOSE THAT APPLY)

HEART TROUBLE* ANEMIA* CANCER* KIDNEY TROUBLE* HIGH BLOOD PRESSURE* BLOOD DISEASE* ARTHRITIS

CIRCULATION DISEASE* LIVER TROUBLE* HARDENING OF ARTERIES* ASTHMA* TUBERCULOSIS* RAYNAUD'S DISEASE

STOMACH ULCERS* VARICOSE VEINS* CRAMPS OR NUMBNESS IN FEET OR LEGS * BROKEN BONES IN FOOT OR LEG **NONE**

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING: (PLEASE CIRCLE THOSE THAT APPLY)

PENICILLIN * NOVOCAINE * ANESTHETICS * BETADINE *CODEINE * ADHESIVE TAPE * RUBBER CEMENT **NONE**

OTHER DRUGS______________________FOODS____________________________MATERIALS___________________

I HEREBY GIVE PERMISSION TO DR DAWN K. DRYDEN AND/OR DR ZERAH ALI TO EXAMINE AND TREAT MY FEET MEDICALLY, SURGICALLY OR ORTHOPEDICALLY.

XX____ __________________
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE DATE

Printed name of patients' representative (if applicable):__________________________________ Relationship:_____________