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?_____ PAIN:____/10 (WORST)

DO YOU HAVE DIABETES? YES NO DATE OF LAST BLOOD SUGAR_____ A1C:_____

HAVE YOU HAD ANY OPERATIONS? (PLS GIVE DATE & TYPE OF OPERATION)_____

_____

MEDICATIONS – LIST BELOW OR PROVIDE US WITH A LIST

MEDICATION	DOSAGE	FREQUENCY

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:_____