

**WELCOME TO  
FAMILY FOOT CARE & SURGERY OF RIDGEFIELD**

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 Responsibility**

I hereby 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 hereby 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 \_\_\_\_\_  
Wound 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**