account # :_____

Concord Foot and Ankle Clinic

Timothy A. Quist, D.P.M., P.C.
24021 US 33 East, Elkhart, Indiana 46517
phone: (574) 875-8698 www.concordfootdr.com

PATIENT INFORMATION

Patient's Name:			Patient's date of birth:
Home address (include zip):			
Mailing address (if different):			
Social Security #:	Home phone #:	Cell phone #:	Marital status:
Patient (or parent) employed by:	Occupation:	Work phone #:	
Work address:			
Name, address & phone number of person to contact in case of emergency:			
How did you hear about our office?	Name & Location of pharmacy of choice:		
Primary insurance company / address:			
Insured's name:			Insured's date of birth:
Secondary insurance company / address:			

MEDICAL HISTORY

Name of family physician:	Date last seen (month/year):
Name of former podiatrist:	What did your former **podiatrist** treat you for?
Please state your reason(s) for coming to our office?	
List all medications (prescription and over the counter) that you are now using or have used in the past month:	
Please give details (including the dates, hospitals, and whether you suffer any continued symptoms) of any recent hospitalization, surgery, or serious injury:	

Patient's height:	Patient's weight:	Patient's shoe size:

Pt _____
account # : _____

Please indicate by checking if you have any significant problems in the below areas:

	diabetes		abnormal bleeding problems
	heart problems		tuberculosis
	high blood pressure		nerve disorders
	Stroke		skin problems
	lung disease		adverse reaction to general anesthesia
	liver disease		difficulty healing or prone to infections
	stomach trouble		thyroid problems
	kidney disease		trouble with vision
	bladder problems		trouble with hearing
	anemia		recent weight loss or weight gain
	Asthma		joint pain or stiffness
	allergies / hay fever		swelling in feet, ankles or legs
	arthritis (specify type:_____)		numbness in feet or legs
	allergic reaction to medication [list medication(s) & reaction(s) below]		low back pain
	tobacco use (past and/or present, # of packs/day)		cramps in feet or legs
	alcohol use - (how often?_____)		mental illness
	if female, is there a chance you could be pregnant?		difficulty walking
	cancer (specify type) _____		other illnesses or problems

Please comment on any area checked above.

Family History: Please indicate the age of your parents (or the ages they were at time of death) and list any illness from above they have or had.

Father:	Mother:

Please inform us of any other important problem not covered above:

I give my permission and authorize Timothy A. Quist, D.P.M. to render examination and treatment of my conditions.

Signature of patient or parent/guardian:	Date: