CENTRAL VIRGINIA FOOT AND ANKLE

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PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Social Security # _____ Age _____ Sex M F

Martial Status M S W D Employer _____ Occupation _____

Email Address _____

*If patient is a minor, please complete Parent/Guardian Information

PARENT/GUARDIAN INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City_____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Birthdate _____ Social Security Number _____

Email Address _____

Employer/Address _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____ Birthdate _____ Phone:_____

Subscriber ID _____ Group Number _____

Secondary Insurance _____

Subscriber Name _____ Birthdate _____ Phone _____

Subscriber ID _____ Group Number _____

EMERGENCY INFORMATION

Name of relative or friend not living with you _____

Relationship _____ Address _____ Phone _____

I give permission to Central Virginia Foot and Ankle to administer to me such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I understand that I am solely responsible for this consent.

Our goal is to provide caring and highly competent foot and ankle care. We can only do this with your help. Please feel free to comment on any aspect of your visit which you feel needs our attention.

_____ _____

Patient/ Guardian Signature Date

Please fill out the back side

MEDICAL HEALTH & HISTORY

Please Answer All Questions

Referred by: ❒ Phonebook ❒ Friend ❒ Physician ❒ Other _____

Describe your foot problem: Primary Care Physician: _____ Date last seen ____/____/_____

Right foot: _____

Left foot: _____

Height: _____ Weight: _____ Shoe Size: _____

Have you ever seen a podiatrist before? Y N Whom and when? _____

Have you had any serious illness in the last three years? _____

Surgical History:_____

FAMILY HISTORY WHO?

Heart Disease …….. Y N _____

Diabetes……..Y N _____

High Blood Pressure…Y N _____

Cancer……....Y N _____

Foot Problems……...Y N _____

ALLERGY

Are you allergic or have you reacted adversely to any of the following?

Local Anesthesia……Y N

Aspirin……..,.Y N

Anti-inflammatories……Y N

Tape or Band-Aids……..Y N

Latex……Y N

Iodine……....Y N

Penicillin…… Y N

Sulfa Drugs…… Y N

Other Antibiotic…… Y N

Codeine…….. Y N

Sedatives…… Y N

Other _____

Type of Reaction _____

PAST MEDICAL HISTORY

Are you being treated for or have you ever been treated for:

Gout……. Y N

Reaction to anesthesia…….. . Y N

Hepatitis…….. Y N

Type_____

Liver disease/jaundice…… … Y N

Skin Rashes or Hives……... Y N

Epilepsy or Seizures……... Y N

Kidney Trouble……., Y N

Emphysema or bronchitis…… Y N

Asthma…… Y N

Tuberculosis…….. Y N

Scarring tendency……,…. Y N

HIV/AIDS……..… Y N

Women, are you pregnant…… Y N

Breast Feeding…… Y N

Diabetes……Y N

yrs _____ type _____

High Cholesterol……...Y N

High Blood Pressure…….Y N

Heart Problems……Y N

type_____

Heart attack/Stroke…….……Y N

Stomach Ulcers…….....Y N

Arthritis…….Y N

Artificial joints or heart valve……..Y N

Rheumatic Fever……...Y N

Cancer or tumor……....Y N

Bleeding Problem…….Y N

Anemia…….Y N

Thyroid Problems…….Y N

Blood Clot, DVT, Phlebitis……..Y N

Do you smoke?..... Y N If so, how many each day? _____How long? _____ Quit?_____

Do you drink alcohol?..... Y N If so, how much?_____How often?_____

Patient/Guardian Signature_____ Date:_____