Welcome To Honeygo Podiatry

Name _____
First Middle Initial Last

Address _____ Apt _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Marital Status S M D W (Circle) Sex M F (Circle)

Language _____

Race: Black/African American ____ White ____ Asian ____ Native Hawaiian/Other Pacific Islander ____ Indian/Alaska Native ____

Ethnicity: Hispanic/Latino ____ Not Hispanic/Latino ____

Employer _____ Phone _____

Address _____

Physician _____ Phone _____

Address _____

Emergency Contact

Name _____ Relationship _____

Emergency Phone _____

Primary Insurance

Company _____ Policy Holder _____ Birthdate _____

Policy Holder's Employer _____ Relationship _____

Policy # _____ Group # _____

Secondary Insurance

Company _____ Policy Holder _____ Birthdate _____

Policy Holder's Employer _____ Relationship _____

Policy # _____ Group # _____

I certify that the above information is correct to the best of my knowledge. I will not hold Edward S. Orman, DPM, PA or any member of his staff responsible for any errors or omissions. I authorize the release of any medical information necessary to process any insurance claims. I authorize payment of medical benefits directly to Edward S. Orman, DPM, PA for myself or my dependants. I understand I am responsible for any deductibles, co-insurance or other amounts not covered by my insurance company. If a referral is required and is not presented at the time of service, I will be responsible for payment.

Signature _____ Date _____

Email Address: _____

PODIATRIC HISTORY

What is the chief complaint for which You came to be treated?_____

_____

_____

Have you ever been to a podiatrist before?
___Yes ___No
If yes, please list:
Name_____

Please indicatewhich foot problems you now have or had in the past.

___Ankle pain
___Athletes foot
___Bunions
___Corns, calluses
___Cramps or numbness in feet or legs
___ Flat feet
___ Heel pain
___ Ingrown toenails
___ Warts
___ Swelling feet/ankles
___ Tired feet

SOCIAL HISTORY

Your occupation_____

_____

Smoke cigarettes____ if yes how many packs per day and for how long_____

Athletic activities in which you participate (please list and indicate frequency)_____

_____

_____

MEDICAL HISTORY

Check symptoms you currently have or had in the past year

GENERAL

__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of Sleep
__ Numbness
__ Sweats

Gastrointestinal

__ Poor appetite
__ Vomiting blood
__ Bowel changes
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Nausea/Vomiting
__ Rectal bleeding
__ Stomach pain

EYE, EAR, NOSE, THROAT

__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Ear ache/discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nose bleeds
__ Persistent cough
__ Ringing in ears
__ Vision flashes/halos
__ Sinus problems

MEN ONLY

__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other_____

WOMEN ONLY

__ Abnormal Pap smear
__ Bleeding betw. periods
__ Breast lump
__ Ext. menst. pain
__ Hot flashes
__ Nipple disharge
__ Painful intercourse
__ Vaginal discharge
__ Other_____
Date last period_____
Date last Pap smear_____
Last mammogram_____
Are you pregnant_____

MUSCLE/JOINT/BONE

Pain, weakness,numbness in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders

CARDIOVASCULAR

__ Chest pain
__ High/low Blood pressure
__ Irregular/rapid heart beat
__ Poor circulation
__ Swelling ankles
__ Vericose veins

SKIN

__ Bruise easily
__ Hives
__ Itching/rash
__ Change in moles
__ Scars
__ Sore that won't heal

GENTO-URINARY

__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

Check conditions you have or had in the past

__AIDS
__ Appendocitis
__ Asthma
__ Arthritis
__ Bleeding disorder
__ Breast lump
__ Cancer
__ Cataracts
__ Chemical dependency
__ Chicken pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Heart disease
__ Hepatitis
__ Herpes
__ High cholesterol
__ HIV positive
__ Kidney disease
__ Liver disease
__ Measles
__ Migraine headaches
__ Multiple sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate problem
__ Rheumatic fever
__ Scarlet fever
__ Stroke
__ Thyroid problems
__ Tuberculosis
__ Ulcers
__Venereal disease

Medications

list any medications you take

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Medication Allergies

List any medication allergies and the reaction

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5._____ _____
6._____ _____

Health Habits

check all substances you use and how much

__ Caffeine_____
__ Drugs_____
__ Tobacco_____
__ Other_____
_____
_____

check if your work exposes you to the following:

__ Stress
__ Heavy lifting
__ Hazardous substances
__ Other_____

I certify that all the above information is correct to the best of my knowledge. I will not hold my Dr. Orman or any members of of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Name (please print clearly)_____

Signature_____ Date_____