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(989) 686-2331

Andrew H. Cohen, D.P.M.

Welcome to Our Office

Patient History

(Please Print)

Today's Date______________________

Patient's Name ____ /Spouse ___________________________

Social Security No. ______________________________________ email address_________________________

Address ____

Street City State Zip

Home Phone ____________________________________ Business Phone _________________________________

Date of Birth ___________________________________ Marital Status __________________________________

Occupation _____________________________________ Employer _______________________________________

Spouse Occupation ______________________________ Spouse Employer _________________________________

Guardian's Name (if patient is a minor)____

Address (if different than parent's) ____

Person to contact in case of emergency ____ Phone ___________________

Address ____

Referred by ____

Insured by ____

What is your foot problem? ____

____

____

When did this problem start? ____

Have you had foot treatment before? __________ If yes, by whom? _______________________________

What was the treatment? ____

____

How have you treated this problem at home? ____

Have you injured your feet before, and if so, how?____

What type of work do you do? ____

Please answer the following questions to the best of your ability:

Your: Height ___________________ Weight ___________________ Shoe Size ____________

(Over Please)

Are you in: ( ) good health ( ) fair health ( ) poor health

Are you subject to prolonged bleeding or healing difficulties? ______________________________

Do you bruise easily? ____________________ Do you have low back pain? ____________________

Are you under the care of a doctor? ( ) Yes ( ) No If yes, state the reason: ______________

____

Physician's name and address ____

Are you on a diet? ____

What medications are you now taking? _____________________________________

____

Are you pregnant? ( ) Yes ( ) No

Do you: smoke (amount) ____________________ drink alcohol (amount) ____________________

( ) I am not allergic to anything to my knowledge

( ) I am allergic to (Please check)

______ Aspirin	______ Mercurials	______ Sutures
______ Novocaine	______ Merthiolate	______ Other ______________
______ Codeine	______ Iodine	______________
______ Demerol	______ Adhesives/Tape	______________
______ Penicillin	______ Nylon, Plastics	______________
______ Sulfa	______ Antihistamines	______________

Please check appropriate places. I have, or have had the following:

______ Diabetes	______ Asthma	______ Anemia
______ Bleeding tendencies	______ Cancer	______ Tumors
______ Epilepsy	______ Glaucoma	______ Gout
______ Heart trouble	______ Kidney trouble	______ High blood pressure
______ Nervousness	______ Rheumatism/Arthritis	______ Stomach ulcers
______ Stroke	______ Tuberculosis	______ Polio
______ Varicose Veins	______ Leg Cramps	______ Arteriosclerosis

If you have not had diabetes, are you aware of any family member who has had it? __________ If so, who? __________

____

Is there anything else we should know? ______________________________________

____

I hereby give permission to Dr. Andrew H. Cohen to treat my foot condition.

Date ____________________ Signature of patient ______________________________

Parent or guardian (if patient is a minor) ______________________________