Date:_____

Save Your Soles Podiatry

Name: _____ Birth Date: _____

Address: _____ City/State_____ Zip _____

Telephone: Home: _____ Cell: _____ (Circle preferred primary contact number)

What is your chief foot complaint? _____

_____

Have your feet ever been X-rayed? _____When? _____

Have you had previous foot care? _____ When? _____

What is your occupation? _____

Marital status (circle one) Married Single Divorced Widow/Widower

Are you presently suffering from any of the following:

____ Diabetes. If yes, how long? _____
____ Kidney Disease _____ Heart Disease
____ Liver Problems _____ Gout
____ Circulation Issues _____ Epilepsy
___ Other: _____

Do you have artificial joints or valves? _____

Are you allergic to any medications? ___ Yes ___ No (If yes, please list them) _____

_____

Please list all medication which you are presently taking: _____

_____

_____

Have you been in the hospital during the past few years? ____ Yes ____ No If yes, what was the reason for the hospitalization? _____

What is your shoe size? _____ Do you exercise? _____ Yes _____ No

Name of personal physician: _____Phone Number: _____
Emergency Contact: _____
Phone Number: _____ Relationship: _____

Who referred you to this office? _____

Please bring picture ID and medical insurance cards on first visit