



PATIENT HEALTH HISTORY

(Please Print)

Patient Name: _____ Date of Birth: _____ Age: _____

How would you like to be addressed? _____ Sex: Male Female

Minor (Accompanied by _____) Single Married Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Other) _____

Email Address: _____

Employer: _____ How long? _____

Occupation: _____ Student: Full-time Part-time

Person Responsible for the Account *(if different from above)*

Name: _____ Date of Birth _____ Relationship _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION - Skip over if you handed in your insurance card

Primary Insurance Company: _____ ID #: _____

Secondary Insurance Company: _____ ID #: _____

Primary Card Holder: Self Other: Relationship: _____

Primary Card Holder's Name: _____ Their DOB: _____

FOOT AND ANKLE CARE

What Problem brings you in today? _____

How long have you had these problems? _____

Have you ever broken a bone in your foot or ankle? Yes (Where and year _____) No

Please indicate current or past foot and ankle problems:

Ingrown Toenail Athlete's Foot Corns & Calluses Cramps or Numbness Flat Feet

Heel Pain Foot or Leg Cramps Swelling Tired Feet Fungus Ankle Pain Warts

