**NORTHVILLE FAMILY FOOT SPECIALISTS**
**42925 W. Seven Mile Road**
**Northville, Michigan 48167**

Date _____

**WELCOME TO OUR OFFICE**

# PATIENT HISTORY

**— PLEASE PRINT When Filling Out This Form —**

Patient's Name _____ /Spouse _____

Address _____
Street City State Zip

Home Phone _____ Business Phone _____

Date of Birth _____ Age _____ Marital Status _____

Occupation _____ Employer _____

Student ☐ Full time ☐ Part time Name of School _____

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

Address (if different than patient's) _____

Person to contact in case of emergency _____ Phone _____

Referred by _____

*Patient's Social Security# _____ *Insured's Social Security# _____

Insured by _____ Insured's Name _____

*Insured's Date of Birth _____

Group# _____ Contract# _____

Medicare# _____ Medicaid# _____

*Co-insurance paid through ☐ Business or ☐ Privately

What is your foot problem _____

_____

When did this problem start _____

Have your 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 _____

You are 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 appropritate 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 |
| _____ Hepatitis | _____ HIV positive | _____ Aids |

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

_____

Have you received a blood transfusion prior to March of 1985? If so, please explain _____

Is there anything else we should know? _____

_____

I hereby give permission to Dr. _____ to treat my foot condition.

Date: _____

_____
Signature of patient

_____
Parent or guardian (if patient is a minor)