Personal Medical History
Barth Wolf DPM and Daniel Reznick DPM

Patient's Last Name ______________________ First ____________________ Middle Int. _____

Mailing address _______________________________ City _____________ State ____ Zip _____

Age _______ Sex _____ Social Security: ______________ Date of birth __________

Home phone _________________ Cell Phone ________________ Work phone ________________

Primary Insurance Company: ____________________________ Policy Holder ________________

Relationship to Patient: ____________________ Date of Birth __________________

Secondary Insurance Company _____________________________ Policy Holder ______________

Relationship to Patient: ____________________ Date of Birth __________________

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible party Name: _____________________________ Phone ______________________

Address _______________________________ City _______________ State ______ Zip ________

If the patient is in a facility (nursing home, rehab…) please list Name _________________________

Address ______________________________ City _______________ State _______ Zip ________

Contact ____________________ Phone ______________________

How did you learn of our office? ____

Describe your foot problem (Give specific location) _______________________________________

____

____

How long has this been bothering you? _____ days # _____ weeks # _____ months # _____ years

Please circle what you feel. You may circle more than one:

Burning Throbbing Sharp Dull Aching Numbness Tingling Shooting

How intense is your pain? 0= none, 10= severe (circle one) 1 2 3 4 5 6 7 8 9 10

What causes the problem or makes it worse? ____

Are there any other problems associated with your foot complaint? (eg; back or leg pain) ____________

Personal Medical History (page 2)

Patients Name ______________________________

List previous and current treatments for this condition ______________________________

____

Do you have any other foot problems that need attention? ______________________________

____

Is this a work injury? Yes No Auto Accident? Yes No Other ______________

SURGICAL HISTORY: Please list all past operations on any part of your body. (Give dates)

____

____

____

Do you have any artificial joints? Yes No Do you have heart valve implant? Yes No

Do you have mitral valve prolapse? Yes No

Social History

Do you smoke? Yes No (if yes, # of packs per day? ______) How many years? _______

Do you drink alcoholic beverages? Yes No (if yes, amount per week? ______________________

Do you use recreational drugs? Yes No

Are you or could you be pregnant? Yes No

Employment: Main activity includes (please circle) Sitting Standing Walking Lifting

The work place floor is: (please circle) Concrete Carpet Rubber mat Other: ____________

ALLERGIES Please check those that apply: ____ No known allergies

____ Erythromycin ____ Aspirin Other ______________________________

____ Iodine / dyes ____ Sulfa drugs ______________________________

____ Metals ____ latex

____ codeine ____ morphine

____ Penicillin ____ Foods ____

Personal Medical History (page 3)

Patients Name ______________________________

MEDICATIONS (**List all medications you take regularly. Include over the counter or non- prescription medications.)**

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

HAVE YOU EVER HAD THE FOLLOWING ILLNESSES (CHECK THOSE THAT APPLY)

MAJOR DISEASE:

___ Diabetes
___ Hypertension
___ Angina
___ Heart Disease
___ Other _________

___ Heart Attack
___ Arrhythmia
___ Murmur
___ Mitral Valve Prolapse
___ Stroke
___ Chest Pain

RESPIRATORY:

___ Asthma
___ Emphysema
___ Shortness of Breath

ARTHRITIS:

___ Osteoarthritis
___ Rheumatoid
___ Gout
___ Fibromyalgia
___ Other _________

VASCULAR:

___ Anemia
___ Sickle Cell
___ Bleeding Disorder
___ Poor Circulation
___ Blood Clots

GASTROINTESTINAL:

___ GI or Rectal Bleeding
___ Stomach Problems
___ Hiatal Hernia

MISCELLANEOUS:

___ Epilepsy
___ Thyroid Disease
___ Muscle Disease
___ Kidney Disease

___ Bladder Problem
___ Prostate Problems
___ Venereal Disease
___ Skin Conditions
___ Cancer; type _____
___ Hepatitis

___ Bowel Disorders
___ Ulcers
___ Acid Reflux

List any of the above diseases / conditions in your immediate family ________________

____

Who is your primary or referring doctor? ______________________________________

Address ______________________ City ____________________ State _____ Zip _____