

Welcome to the Seaford Foot Care Center

First name: _____ Last name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Email: _____

Marital status: () Married () Single () Divorced () Widowed Cell phone: _____

Business phone: () _____ Sex () Male () Female

Social Security # _____ Date of birth _____

Family physician _____ City _____ Phone _____

Whom may we thank for referring you to our office? _____

Primary insurance _____ Policy # _____

Name of insured _____

Address of insured _____

Sex: () Male () Female Date of birth: _____

Relationship of patient to insured: 0 – Self 1 – Spouse 2 – Child

Secondary insurance _____ Policy # _____

Name of insured _____

Address of insured _____

Sex: () Male () Female Date of birth: _____

Relationship of patient to insured: 0 – Self 1 – Spouse 2 – Child

Chief complaint that brought you to our office: _____

MEDICAL HISTORY:

Do you have or have you had any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Abnormal heart condition	___	___	Emphysema	___	___	Phlebitis	___	___
Anemia (low blood count)	___	___	Epilepsy	___	___	Pneumonia	___	___
Rheumatic fever	___	___	Fainting	___	___	Arthritis	___	___
Rheumatoid arthritis	___	___	Gout	___	___	Asthma	___	___
Bleeding abnormality	___	___	Sciatica	___	___	Hepatitis	___	___
Circulation problems	___	___	Stroke	___	___	Thyroid	___	___
High blood pressure	___	___	Lungs	___	___	Ulcers	___	___
Varicose veins	___	___	Kidney	___	___	GI	___	___
Leg cramps while walking	___	___	Joint pain	___	___	Chest pain	___	___
Tuberculosis	___	___	Diabetes	___	___	Cancer	___	___

Family history of diseases (Diabetes, Heart disease, Cancer, etc.):

Past surgeries:

(tonsils, appendectomy)

Current medications:

Allergies:

() Penicillin () Sulfa drugs () Seasonal (hay fever)

Other:

Athletic activities: () Walk

() Run

Frequency

Other:

(ex: soccer, baseball, basketball, rollerblade, gym, etc)

Social history:

Smoke () No

Yes ()

___ Packs/day for ___ years.

Quit _____

Alcohol () No

Yes ()

() Socially () Daily