HISTORY & PHYSICAL FORM

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Please read & complete front/back of all pages PRIOR to your appt. There will not be enough time at your visit to do so.

Welcome to my office. Please print your responses **IN BLACK INK** to the following questions. This is part of your medical record.

Patient's Given Name_____ Date _____

Street _____City/State/Zip _____

Home Phone _____Cell _____ Work_____

Sex F M Birth date _____ Age_____ Social Security No._____

Circle one single divorced partner / partnered widow / widower married-spouse's name_____

Emergency contact – (should something happen to you while you are in our office)

_____

name(s) relationship phone numbers (H) (W) (cell)

Full time ____

PRIMARY Insured's Employer_____Business phone _____ Part time____

Business address_____Occupation_____

Name of Pharmacy _____ **Address** _____**Phone** _____

HEALTH INSURANCE PLAN(S) UNDER WHICH YOU ARE COVERED.

1. _____through self_____ through spouse _____through parent _____
   If through spouse/parent need date of birth _____ spouse/parent SS# _____
2. _____through self_____ through spouse _____through parent _____
   If through spouse/parent need date of birth _____spouse/parent SS# _____

If you are a new patient, how did you find out about the office? _____

MEDICAL INFORMATION

First and last name of family doctor_____

Complete address of family doctor_____

Doctor's phone #_____Last visit _____Are you currently under your doctor's care? Yes No

If so, for what reason? _____

What is your height? _____ weight? _____ shoe size (Length & Width)_____

Do you think that your weight is contributing to your foot pain? _____

If so, are you interested in a healthy lifestyle change to lose weight? _____

If you are a new patient, have you had previous treatment by a podiatrist? Yes No

When? _____ For what? _____

What is the reason for your visit today? _____

_____

What medications are you currently taking? **(please include aspirin, vitamins, herbal meds, or birth control pills)**

Please list _____

_____

_____

_____

Do you or have you had any of the following? Please check.

___ Diabetes
___ Heart issues
___ Epilepsy
___ Liver issues
___ Kidney issues
___ TB
___ High blood pressure
___ Stomach/Intestinal ulcers
___ Asthma
___ Emphysema
___ Muscle problems
___ HIV/AIDS
___ Glaucoma
___ Anemia
___ Stroke
___ Arthritis – osteo? rheumatoid?
___ Cancer
___ High Cholesterol
___ Bleeding problems
___ Thyroid issues
___ Rheumatic/Scarlet fever
___ Skin rashes
___ Hepatitis
___ Mood Swings
___ Osteoporosis
___ Irritability
___ Abdominal Bloating
___ Sleep Disturbances
___ Depression
___ Acid reflux
___ Bronchitis
___ Anxiety
___ Other

Medical Conditions in your family (make reference to the list above)

Mother:

Father:

Sister(s):

Brother(s):

Are you allergic to.....

___ Novocaine
___ Penicillin
___ Sulfa
___ Codeine
___ Iodine dye
___ Other

What type of reaction occurs? _____

_____

Do you smoke? _____ How many packs/day? _____ Previous smoker? ____ How long? _____

Do you use alcohol?_____ How much do you drink/week?_____

Please list any surgery you have had since childhood.

_____

_____

_____

_____

Are you interested in treating your problems through natural health remedies such as acupuncture, nutritional recommendations, supplements, etc? yes no maybe

How much change are you willing to make at this time for improving your health? 10% 30% 50% 80% 100%

Is there anything else we should know about your general health?

_____

_____

_____

I hereby give Dr. Ferrelli permission to examine and treat my foot condition.

_____ _____

Signature Date