

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 Given Name _____ Date _____
Street _____ City/State/Zip _____
Home Phone _____ Cell _____ Work _____
Sex F M Birth date _____ Age _____
Circle one single divorced partner 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)

Insured's Employer _____ Business phone _____ Full time _____ Part time _____
Business address _____ Occupation _____
Business Fax _____
Name of Pharmacy _____ Pharmacy Phone _____

Name of medical and/or surgical insurance companies 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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Heart issues | <input type="checkbox"/> Anemia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Liver issues | <input type="checkbox"/> Arthritis – osteo? rheumatoid? | <input type="checkbox"/> Abdominal Bloating |
| <input type="checkbox"/> Kidney issues | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> TB | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Stomach/Intestinal ulcers | <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic/Scarlet fever | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Other, please list |
| <input type="checkbox"/> Muscle problems | | |

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

Mother:

Father:

Sister(s):

Brother(s):

Are you allergic to.....

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine dye |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other |

What type of reaction occurs?

Do you smoke? _____ How many packs/day? _____

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