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____________

Email ____

Sex F M Birth date ________________ Age________

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)

PRIMARY Insured's Employer__________________________Business phone ___________ Full time ____ 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 practice? ____________________________________

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 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 disease
___ 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 IMMEDIATE family, EVEN IF DECEASED (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.

____
____
____
____

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