COMPREHENSIVE FOOT & ANKLE CARE

Kimberly Ciccero, DPM

DATE: ____/_____/_____

PATIENT NAME:

_____________________________________________________________________________

Last First MI

DATE OF BIRTH: ____/____/____ SSN______________________________

HOME ADDRESS:

STREET________________________________________________________________________

CITY/STATE: ____________________________________ ZIP: ____________

CELL PHONE #: (_____) _____-________ MAY WE LEAVE A MESSAGE/TEXT? YES NO

ALT. PHONE #: (_____) _____-_________ MAY WE LEAVE A MESSAGE? YES NO

E-MAIL: ___________________________________________________________ SEX: M F

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? ___YES___NO

IF YES, NAME: ______________________________________________RELATIONSHIP: ____________

PHONE #: (_____) _________-_____________

EMERGENCY CONTACT: ____________________________________RELATIONSHIP: ______________

PHONE #: (_____) _________-______________

PRIMARY CARE DOCTOR: ______________________________ PHONE #: (_____) _____-___________

DATE OF YOUR LAST PRIMARY CARE DOCTOR VISIT__________________________

PHARMACY: (Name/Location) ________________________________ PHONE #: (_____) _____-_______

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME OF MEDS DOSE REASON?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

ALLERGIES: ___NONE KNOWN ____YES (IF YES, PLEASE LIST)

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

MEDICAL PROBLEMS: List all medical conditions below:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**CURRENT PROBLEM (CHIEF COMPLAINT)**
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

________________________________________________________________________________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

________________________________________ DATE ________________________________
SIGNATURE (PATIENT, PARENT OR GUARDIAN)