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 DOCOTOR VISIT___________________________

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

SOCIAL HISTORY:

MARITAL STATUS: ___ SINGLE___ MARRIED___ PARTNERED___ SEPARATED___ DIVORCED ____WIDOWED

USE OF ALCOHOL: ___NO ____YES

COMPREHENSIVE FOOT & ANKLE CARE

Kimberly Ciccero, DPM

USE OF TOBACCO: ____NEVER____YES _____QUIT (HOW LONG AGO?) _____

USE OF RECREATIONAL DRUGS: ____NEVER____YES _____QUIT (HOW LONG AGO?) _____
TYPE ____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE

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

NAME OF MEDS DOSE REASON?

<u>YOUR MEDICAL HISTORY</u>

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

Medical Problems: Which of the following conditions are you currently being treated or have been treated for in the past (please check)

□Heart Disease /Murmur / Angina □Shortness of Breath □Eye Disorder / Glaucoma □Diabetes
□High cholesterol □Asthma □Seizures □Kidney / Bladder problems □High blood pressure

COMPREHENSIVE FOOT & ANKLE CARE

Kimberly Ciccero, DPM

□Lung problems / cough/ COPD □Stroke □Liver problems / Hepatitis □Low blood pressure □Sinus problems □Headaches / Migraines □Arthritis (rheumatoid or osteoarthritis) □Heartburn (reflux) □Seasonal allergies □Neurological problems □Cancer □Anemia or blood problems □Tonsillitis □Depression / Anxiety □Ulcers/colitis □ Hepatitis _____□Swollen ankles □Ear problems □Psychiatric care □Thyroid problems □Infectious Disease (HIV, AID's)

Others/any additional information regarding your medical conditions

____
____
____

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 __________________________________

SIGN NAME OF PATIENT, PARENT OR GUARDIAN