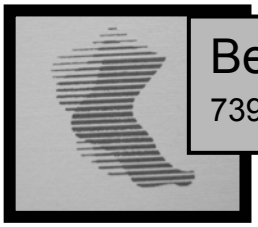

Beltline Podiatry

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Thank you for visiting our office. We would like to give you the highest quality of care available.
Please help us by filling out the information below to learn more about you and your health.

PERSONAL INFORMATION

First Name:	MI:	Last Name:	Sex:	Social Sec #:	Birth Date:	Age:
Address:		City:	State:	Zip:	How were you referred?	
Phone Number: Home: (_____) _____ - _____ Work: (_____) _____ - _____ Other: (_____) _____ - _____		Emergency Contact/Relationship: _____ Day: (_____) _____ - _____ Evening: (_____) _____ - _____	Please Provide us with your Pharmacy _____ Address: _____ Phone Number: (_____) _____ - _____		Please Circle: Married Single Widowed Divorced	
Patient's Employer:		Primary Insurance Co:	Subscriber's name:		Subscriber's birthdate:	
Secondary Ins Co:		Subscriber's name:	Subscriber's employer:		Subscriber's birthdate:	
Family Doctor:		Address:	Phone #: (_____) _____ - _____		Last Visit	
Previous Foot Doctor:		Foot Problem:				

COMPREHENSIVE MEDICAL HISTORY (So that our records are accurate, please fill in all information. Thank you)

List any allergies to Medications. If there are none, please state none.

Height:

Weight:

Have you had treatment for: Please circle either y for yes or n for no

___ NONE OF THESE	y / n Broken Foot Bones	y / n Corns	y / n Hammertoes	y / n Knee Pain	y / n Ulcers of Feet/Legs
y / n Arch Pain	y / n Bunions	y / n Cramps in Feet/Legs	y / n Heel Pain	y / n Low Back Pain	y / n Walking Problems
y / n Athlete's Foot	y / n Callouses	y / n Flatfeet	y / n High Arched Feet	y / n Neuroma	y / n Warts
y / n Broken Ankle	y / n Childhood Foot Problems	y / n Fungal Nails	y / n Ingrown Nails	y / n Numbness in Feet	y / n Ankle Sprains

Do you have or have ever been treated for: Please circle either y for yes or n for no

___ NONE OF THESE	y / n Chest Pain	y / n Joint Pain / Stiffness	y / n Diabetes	y / n Cancer	y / n Stroke
y / n Weight loss / gain	y / n Lung Disease	y / n Arthritis	y / n Frequent Urination	y / n Scars / Keloids	y / n Thyroid Problems
y / n Weakness /Fatigue	y / n Shortness of Breath	y / n Liver Problems	y / n Confusion	y / n Rheumatic Fever	y / n Leg Swelling
y / n Headaches	y / n Naseau / Vomiting	y / n Hepatitis	y / n Depression	y / n Sore Throat	y / n Heart Attack
y / n Vision Problems	y / n Stomach Ulcers	y / n Circulation Problems	y / n Nerve Disorders	y / n Seizures	y / n Other: _____
y / n Heart Disease	y / n Abdominal Pain	y / n Kidney Problems	y / n Asthma	y / n Bleeding Tendencies	_____

Do you have vascular grafts? _____
Do you have heart valve replacements? _____
Do you have joint replacements? _____
Are you under active chemotherapy? _____
Have you had any other serious illnesses? _____
Have you had any surgery or complications to surgery?

Surgery for:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

List any family members who have had the following:

Arthritis: _____ High Blood Pressure: _____
Blood Clots: _____ Keloid Former: _____
Cancer: _____ Stroke: _____
Diabetes: _____ Other: _____
Heart Attack: _____

Is your Mother Living? ____ Age? ____ Is your Father Living? ____ Age? ____

Social History: Do you smoke now? _____ Packs/day? _____ Years? _____
Did you ever smoke? _____ Packs/day? _____ Years? _____
If you quit when did you do so? _____
Alcoholic Beverages? None Rarely Moderately Daily Quit
Recreational Drugs? None Rarely Moderately Daily Quit
Hobbies: _____

Medications currently taking	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I authorize Dr Clay to treat my foot/ankle condition. I authorize the release of medical or other information necessary to process this claim. I authorize payment of medical benefits to the physician for all services.

Patient Signature: _____ **Date:** _____
(signature of parent or guardian if minor)