

BRIEF PATIENT RECORD

Please fill out completely

Dr. _____ TODAYS DATE _____ Account # _____
Location: **Ford Center For Foot Surgery**

Patients full name:

Last _____ First _____ MI _____ Sex M F

Patient SS # _____ Date of Birth _____

Marital Status S M D W Name of Spouse _____

Phone _____ Work _____ Cel _____

Local Address _____

City _____ State _____ Zip _____

Second or out of state Address _____

City _____ State _____ Zip _____

Pharmacy # _____ E-Mail _____

Employer Name _____ Job Title _____

Company Phone _____ Address _____

How did you hear about us? _____ If referred, by whom? _____

Name and **relationship** of Emergency Contact _____

Phone number of Emergency Contact _____

Name of Family Physician _____ Date last seen: _____

Phone _____ Fax _____

Address _____

SIGNATURE OF RESPONSIBLE PARTY

DATE

Person responsible for services rendered if different than listed above

Name _____ SS# _____

Address _____

Phone _____ DOB _____

Please describe what brings you to the office today?

Name of Primary Care / Family Physician (first and last name) ?

Date last seen by Primary Care / Family Physician (month, day and year if known)

Past medical history:

hypertention/high blood pressure HIV/AIDS hepatitis heart attack/MI
insulin dependent diabetes non insulin dependent diabetes stroke/CVA aneurysm
blood clot

Past medical history – injuries/trauma

Have you had any of the following foot surgeries:

toenail bunion hammertoe fracture repair joint fusions
tendon repair/rerouting ankle stabilization arthroscopy
fasciotomy

Please list approximate month and year of any surgery listed above:

Past Surgical History: Have you had any of the following surgeries?

heart bypass heart valve repair/replacement appendectomy
gallbladder brain surgery other

Please list approximate month and year of any surgery listed above:

Any other surgeries? (Please specify type of surgery and date)

Social History - Do you:

smoke tobacco smoke marijuana use hallucinogenic drugs
drink alcohol use cocaine use other recreational drugs

Alcohol, number of drinks

Number of drinks a day _____ greater than 5 per day _____ 1-3 drinks per week
4-6 drinks per week occasional use social drinking only week end drinking only

Social Smoker, number of packs per day

_____ number of pack per day 5 or more packs per day 1-2 packs per week 3-4 packs per week
Occasional smoking only social smoking only weekend smoking only

If you use other recreational drugs - please list/specify:

Medications - please list medications (including aspirin) currently taking:

Allergies - Do you have allergies to any of the following:

drug allergies penicillin sulfa erythromycin
aspirin cortisone codeine adhesive tape
local anesthetics **no known allergies**

Other allergies to medications - please list:
