Mount Dora Podiatry

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Patient Data Sheet - Please complete entire form

Today's Date: _____ Referred By: _____

Date of Injury (if applicable):_____ Detail Injury: _____

Patient's Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: _____ Age: _____ M:_____F: ____

Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____

Parent or Guardian Name: _____ Date of Birth: _____

Occupation: _____ Employer: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's name: _____ Insured's SS #: _____ Date of Birth: _____

Insured's employer: _____ Insured's work # _____

Name of primary care physician: _____ Date last seen: _____

EMERGENCY CONTACT: _____

Relationship: _____ Phone #: _____

REASON FOR TODAYS VISIT: _____

How long have you had this problem? Weeks: _____ Months: _____ Years: _____

Has any other doctor treated you for this problem in the past: Yes: _____ No: _____

If yes please explain: _____

General Health: _____

Pharmacy name: _____ Location: _____

Medications: _____

Allergies: _____

Exercise: None: _____ Daily: _____ Weekly: _____ Type and amount: _____

Do you drink alcohol? No: _____ Yes: _____ Amount: Daily /Weekly/Monthly/Yearly (circle one)

Do you smoke? No: _____ Yes: _____ Amount: _____ How long? : _____

When did you quit? :_____

Family History (please list any major illness for family members listed below:

Mother: _____ Father: _____

Brother/s: _____ Sister/s: _____

Mount Dora Podiatry
Review of Systems

Patient Name: _____ Date of Birth: _____

Please place a checkmark if you have the following conditions or illnesses

General (recent)
___ Weight gain___lb
___ Weight loss___ lb
___ Weakness
___ Fatigue
___ Fever

Eyes
___ Glaucoma
___ Blind

Ear, Nose and Throat
___ Ear infection **(recent)**
___ Dizziness
___ Hearing loss

Cardiovascular
___ High Blood Pressure
___ Heart Problems
___ Atrial Fibrillation
___ Swelling feet and ankles
___ History of blood clot
___ Varicose Veins

Respiratory
___ Sleep Apnea
___ Tuberculosis
___ Asthma
___ Emphysema
___ COPD

Gastrointestinal
___Stomach ulcers
___ Hiatal hernia
___ Reflux
___ Liver disease
___ Hepatitis, B or C

Genitourinary
___ Recent UTI
___ Kidney failure/disease

Musculoskeletal
___Rheumatoid arthritis
___Pain: Heel ___
Foot __ Ankle __
___ Low back pain
___ Pain radiating down legs
___ Gout
___ Other

Skin
___ Ulcerations
___ Open sores or wounds
___ Rashes
___ History of MRSA
___ Ingrown toenail
___ Skin cancer: Type _____
Location _____

Neurological
___ Migraine headaches
___ Memory loss
___ Parkinson's
___ Stroke
___ Seizures
___ Tremors
___ Numbness in feet

Psychiatric
___ Anxiety
___ Bipolar
___ Depression

Endocrine
___ Diabetes
___ Thyroid

Hematology
___ Anemia
___ Bleeding problems
___ HIV
___ Cancer: Type_____

Allergies
___ Latex
___ Adhesive tape
___ Medications
___ Environmental
___ Food

Misc
___ Chemical dependency
___ Are you currently pregnant
___ Are you taking a blood thinner?

Previous surgeries and date
_____
_____
_____
_____
_____

This checklist review and list of surgical procedures is accurate and complete to the best of my knowledge. I hereby give my permission to **Janet L Black DPM** known as the physician of Mount Dora Podiatry to examine and perform necessary diagnostic testing and treat my foot and or ankle condition.
I authorize photographing of my feet.

_____

Signature of Patient/ Parent/ Guardian Date