

# ACTIVE FOOT & ANKLE CARE, LLC

**RICHARD T. BRAVER, D.P.M.**  
**PHILIP S. MESSENGER, D.P.M.**

**SUNEEL K. BASRA, D.P.M.**  
**STEPHANIE I. HOCHMAN, D.P.M.**

**140 Grand Avenue Englewood, N.J. 07631 201-569-7672**  
**4-14 Saddle River Road Fair Lawn, N.J. 07410 201-791-1881**  
**1069 Ringwood Avenue, Haskell, NJ 07420 973-831-1774**

## PATIENT INFORMATION SHEET

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer & Address \_\_\_\_\_

Student: Year \_\_\_\_\_ School \_\_\_\_\_ Coach \_\_\_\_\_ Shoe Size \_\_\_\_\_

Sports, Activities or Hobbies \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Doctor & Town \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Social Security \_\_\_\_\_

Do you have or have you had any of the following: (\*do not know)

YES NO DNK			YES NO DNK			YES NO DNK			Are you allergic to or sensitive to			
									YES NO DNK			
Foot / Leg Surgery... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout .....	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot / Leg Injuries <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot / Leg Cramps. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells..	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot / Leg Numbness <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeder.....	<input type="checkbox"/>	<input type="checkbox"/>	Materials.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease...	<input type="checkbox"/>	<input type="checkbox"/>	Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unequal Leg Length. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Issues	<input type="checkbox"/>	<input type="checkbox"/>	Foods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak Ankles..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening Arteries	<input type="checkbox"/>	<input type="checkbox"/>	Stainless Steel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bunions..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins...	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Skin Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Other (if so describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toe Nail Problems... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Low Back Pain..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prone to Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____			

List any medical conditions you have. \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_

Have you had any injuries or operations on your feet or legs? \_\_\_\_\_

Have your or any family members been treated for diabetes? \_\_\_\_\_ If yes. Who? \_\_\_\_\_

List any allergies to medications. \_\_\_\_\_

Present medications being taken: \_\_\_\_\_

My chief complaint is: \_\_\_\_\_

I hereby give permission to Richard T. Braver D.P.M, and/or Associates for the examination and rendering care for my foot/ankle problem and / or related condition.

Date \_\_\_\_\_ Patient Signature ( if minor, parents) \_\_\_\_\_