ACTIVE FOOT & ANKLE CARE, LLC

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Name_____Birth Date_____Age_____Weight_____Height_____

Address_____City_____State_____Zip_____

Home Phone(___)_____Cell Phone(___)_____Work Phone(___)_____
(Please indicate which is the best number to contact you by marking an *)

Gender M – F Marital Status_____ E-Mail Address_____Pharmacy/Address_____

Preferred Language _____ Preferred Phone Communication Home Work Cell
(As required under the new billing insurance guidelines)

Race _____ Ethnicity_____ Referred by_____

Occupation_____ Employer & Address _____Employment Status P/T or F/T

Student: Year_____School_____Coach_____Shoe Size_____

Sports, Activities or Hobbies_____ 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
Foot / Leg Surgery…	□	□	□	Heart Trouble…….	□	□	□	Gout …….	□	□	□
Foot / Leg Injuries...	□	□	□	Diabetes…….	□	□	□	Anemia…….	□	□	□
Foot / Leg Cramps.	□	□	□	Epilepsy…….	□	□	□	Fainting Spells..	□	□	□
Foot / Leg Numbness	□	□	□	Liver Disease…….	□	□	□	Bleeder……	□	□	□
Knee Pain……	□	□	□	Kidney Disease……..	□	□	□	Blood Disease…	□	□	□
Unequal Leg Length.	□	□	□	Rheumatic Fever……	□	□	□	Circulation Issues	□	□	□
Weak Ankles……	□	□	□	High Blood Pressure..	□	□	□	Hardening Arteries	□	□	□
Bunions…….	□	□	□	Polio……	□	□	□	Varicose Veins…	□	□	□
Foot Skin Problems .	□	□	□	Bursitis……	□	□	□	Arthritis……	□	□	□
Toe Nail Problems…	□	□	□	Stomach Ulcers……	□	□	□	Cancer……	□	□	□
Low Back Pain…….	□	□	□	Asthma…….	□	□	□	Prone to Infection	□	□	□

Are you allergic to or sensitive to

	YES	NO	DNK
Novacaine……	□	□	□
Penicillin…….	□	□	□
Adhesive Tape……	□	□	□
Materials…….	□	□	□
Drugs……	□	□	□
Foods……	□	□	□
Stainless Steel……..	□	□	□
Latex……	□	□	□
Other (if so describe)	□	□	□
_____			
_____			

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)_____

Saved as:f:/k documents/ routing/patient info sheet 2014