

**“YOUR FEET NEED A DOCTOR OF THEIR OWN”**

**Dr. David M. Fischman – Podiatrist**

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**www.fischmanfootandankle.com**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name: |  |  | Date of Birth: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Florida Address: |  |  | City: |  |  | State: |  |  | Zip: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Out of State Address: |  |  | City: |  |  | State: |  |  | Zip: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Primary Phone #: |  |  | Secondary Phone#: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Marital Status: |  |  | Social Security Number: |  |  | Male: |  |  | Female: |  |

|  |  |
| --- | --- |
| Guardian for Minor less than 18 years old: |  |

|  |  |
| --- | --- |
| Email Address: |  |

|  |  |
| --- | --- |
| Primary Language Spoken: |  |

|  |  |
| --- | --- |
| Employer name/ phone number: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Spouse’s name/number: |  |  | Emergency Contact: |  |

|  |  |
| --- | --- |
| Family Doctor name and phone number: |  |

|  |  |
| --- | --- |
| When was the previous time you visited Family Doctor: |  |

|  |  |
| --- | --- |
| Drug Store name and phone number: |  |

|  |  |
| --- | --- |
| **How did you hear about out office?** |  |

I give permission to Fischman Foot & Ankle to release any information requested by my insurance company. I also give permission for Fischman Foot & Ankle to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to Fischman Foot & Ankle for service provided.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient/Guardian Signature |  | Date |

|  |  |
| --- | --- |
| and leg) |  |
|  | |
|  | |
|  | |

|  |  |
| --- | --- |
| When did it start? |  |
|  | |

|  |
| --- |
| What is the chief complaint for which you came to be treated? (Include foot, ankle |

|  |
| --- |
| What treatment have you tried before? |
|  |
|  |
|  |

**ALLERGIES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Adhesive Tape | | | |
|  | Aspirin | | | |
|  | Codeine | | | |
|  | Demerol | | | |
|  | Iodine | | | |
|  | Local Anesthetics | | | |
|  | Novocaine | No Allergies | |  |
|  | Penicillin | Other |  | |

**MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Aids / HIV | | |
|  | Anemia | | |
|  | Anxiety | | |
|  | Arthritis | | |
|  | Artificial Heart Value/Joints | | |
|  | Bleeding Disorders | | |
|  | Blood Clot/DVT | | |
|  | Cancer/Type | | |
|  | Circulatory Problems | | |
|  | Depression | | |
|  | Diabetic (**Enter “1” for TYPE-1, or “2” for TYPE-2**) | | |
|  | Epilepsy/Seizures | | |
|  | Flu Shot | | |
|  | Glaucoma | | |
|  | Gout | | |
|  | Heart Disease | | |
|  | Hepatitis |  | Phlebitis |
|  | High Blood Press |  | Respiratory |
|  | High Cholesterol |  | Shingles Shot |
|  | Hypothyroidism |  | Stomach Ulcers |
|  | Kidney Problems |  | Stroke |
|  | Liver Disease |  | Varicose Veins |
|  | Low Blood Press |  | Other |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you seen a Podiatrist before? | | |  | Please indicate any family history of foot or ankle problems: | |
|  | | |  |  | |
| If yes, Name: | |  |  | Ankle Pain |  |
|  | |  |  | Athletes Foot |  |
|  | |  |  | Bunions |  |
| Last Visit: |  | |  | Corns and Calluses |  |
|  |  | |  | Flat Foot |  |
|  | |  |  | Foot/Leg Cramps |  |
| Previous Foot Problems: | | |  | Heel Pain |  |
|  | Ingrown Toenails |  |
|  | Numbness Foot/leg |  |
|  | Plantar Warts |  |
|  | Swelling Ankles/Feet |  |
|  | |  |  | Tired Feet |  |
|  | |  |  | Other |  |

**MEDICATIONS**

**Please list all medications with dosage and strength**

|  |
| --- |
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**SURGICAL HISTORY**

**Please list any surgeries you have had**

|  |
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**SOCIAL HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you smoke |  |  | Amount |  |  | Per day / week |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you drink alcohol |  |  | Amount |  |  | Per day / week |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | SHOE SIZE |  |  | WIDTH |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | HEIGHT |  |  | WEIGHT |  |