

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

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

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**(561) 575-2266 \* Fax: (561) 745-8510**

**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 |

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

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

|  |
| --- |
| 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**

|  |
| --- |
|  |

**SURGICAL HISTORY**

 **Please list any surgeries you have had**

|  |
| --- |
|  |

**SOCIAL HISTORY**

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

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

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

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