# Podiatry Associates, LLC

**DOCTORS OF SURGICAL PODIATRY**

3053 Center Point Rd. N.E., Suite B • Cedar Rapids, Iowa 52402-4049 • Phone: (319) 365-6973 • Fax (319) 365-6974
208 East Main • Anamosa, Iowa 52205 • Phone: (319) 462-3709
717 East Main Street • Manchester, Iowa 52057 • Phone: (563) 927-2944

Name: _____ Preferred Name: _____

SSN: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Preferred method for appointment reminders: Call Text Email: _____

Name of Spouse: _____ Employer of Spouse: _____

Emergency Contact: _____ Phone Number: _____

Are you diabetic? Y / N If yes, date of last A1C: _____ Results: _____ Flu shot: Y / N

Shoe size: _____ Weight: _____ Height: _____

Family Physician: _____ Referring Physician: _____

City: _____ City: _____

Current Medications: _____

_____

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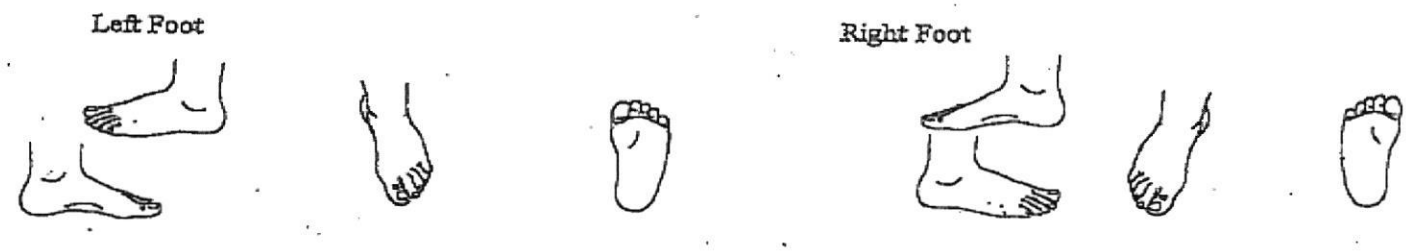
Briefly describe the reason for your visit today AND indicate by marking with an "X" on the diagram:




Is this problem due to an injury or trauma? (If so, please explain) Y / N _____

Describe your foot/ankle pain: (*circle all the apply*) **MILD MODERATE SEVERE THROBBING CONSTANT INTERMITTENT BURNING NUMBNESS OTHER:** _____

Please circle and past or present conditions that apply to you:

| | | | | | |
|---|---|---|---|---|---|
| Anemia | Asthma | | | | Circulatory Problems |
| Gout | Diabetes | Stroke | Hepatitis | Heart Problems | Nervousness |
| Blood Clots | Cancer | Kidney Problems | Glaucoma | Pneumonia | Stomach Ulcers |

Are there any other serious medical conditions we should be aware of? _____

Do you have any allergies to medicines or tape: _____

Signature: _____ Date: _____

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PAST MEDICAL HISTORY: Please indicate any major surgeries or hospitalizations, and if there were complications.

| Hospitalizations/ Surgeries (type)/ Major Injuries | Year | Complications (if any) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

FAMILY HISTORY: Please complete to the best of your knowledge.

| | Alive | Deceased | If deceased, cause of death | Health Status | | |
|---|---|---|---|---|---|---|
| Mother | | | | Good | Poor | Excellent |
| Father | | | | Good | Poor | Excellent |
| Sister/Brother | | | | Good | Poor | Excellent |
| Children | | | | Good | Poor | Excellent |

SOCIAL HISTORY: Please answer all questions.

Are you employed? Yes No If yes, occupation: _____

Marital status: _____ Do you have children? Yes No

Do you live with: Spouse Relatives Alone Other

Do you exercise? Yes No If yes, what type or kind of exercise? _____

Are you on any kind of special diet? Yes No If yes, what: _____

Have you had a history of substance abuse? Yes No If yes, please explain: _____

_____

Do you smoke? Yes No If no, have you ever? Yes No

If yes, how long: _____ How many packs per day? _____

Do you drink alcohol? Yes No If yes, how much? _____ How often: _____

_____ _____

Signature Date