

# Family Foot Health Center New Patient Registration Form

## Personal Information

Full Name: \_\_\_\_\_ Gender: **M** **F**  
*First M.I. Last*

Address: \_\_\_\_\_  
*Street Address City State ZIP Code*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Best # to reach you: **Home** **Cell** **Other**

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Marital Status: **Married** **Single** **Separated** **Divorced** **Widowed**

Who Referred You to our Office? \_\_\_\_\_

Reason for today's Visit: \_\_\_\_\_ Were you Injured? **Yes** **No**

If Injured, Date: \_\_\_\_\_ Place: \_\_\_\_\_ Nature of Injury: \_\_\_\_\_

If Injured, are you currently working: **Yes** **No** If not, last day worked: \_\_\_\_\_

Any Hospitalization: **Yes** **No** Hospital Name: \_\_\_\_\_

Admitted Date & Time: \_\_\_\_\_ Released Date & Time: \_\_\_\_\_

## Job Information

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

## Spouse Information

Spouse's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City, St Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Pone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Work Fax: ( ) \_\_\_\_\_

## Emergency Contact Information

Full Name: \_\_\_\_\_  
*First M.I. Last*

Primary Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

*Please check all positive answers. Write in any missing information*

**Review of Symptoms**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Are you pregnant?            | <input type="checkbox"/> Frequent Urination        | <input type="checkbox"/> Rashes/Itching       |
| <input type="checkbox"/> Blood in Urine               | <input type="checkbox"/> Headache                  | <input type="checkbox"/> Recent Vision Change |
| <input type="checkbox"/> Changes to Skin or Nails     | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Recent Weight Loss   |
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Joints Pain/Stiffness     | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Decrease Circulation to Legs | <input type="checkbox"/> Leg Cramps/Muscle Pain    | <input type="checkbox"/> Weakness/Fatigue     |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Nausea/Vomiting           |   |
| <input type="checkbox"/> Excessive Thirst or Hunger   | <input type="checkbox"/> Numbness/Tingling in Feet |   |

**Past Medical History**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Diabetes-Type II         | <input type="checkbox"/> Liver disease/hepatitis |
| <input type="checkbox"/> Alcoholism/drug dependency  | <input type="checkbox"/> Difficulty healing       | <input type="checkbox"/> Lung problems           |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Fainting spells/epilepsy | <input type="checkbox"/> Neurological disorder   |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Organ transplant        |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Head trauma              | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Back injury                 | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Rheumatoid arthritis    |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Skin condition          |
| <input type="checkbox"/> Circulation problem to legs | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Stomach ulcers          |
| <input type="checkbox"/> Congestive heart failure    | <input type="checkbox"/> Hormone deficiency       | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Intestinal problems      | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Diabetes-Type I             | <input type="checkbox"/> Kidney disorder          |  |

**Family History**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism/drug dependency | <input type="checkbox"/> Circulation problem to legs | <input type="checkbox"/> High cholesterol      |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Bleeding disorders         | <input type="checkbox"/> Flat feet                   | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Bunions                    | <input type="checkbox"/> Hammertoes                  |  |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Heart disease               |  |

**Medication (Dosage & Frequency):**

_____	_____
_____	_____
_____	_____

**Drug Allergies (include reactions):** \_\_\_\_\_  
\_\_\_\_\_

**Miscellaneous**

Cigarettes:  (\_\_\_\_ packs/day X \_\_\_\_ yrs)    Alcohol:  (\_\_\_\_ drinks/day)    Height: \_\_\_\_\_    Weight: \_\_\_\_\_

List all other doctors you have seen for this condition: \_\_\_\_\_  
\_\_\_\_\_

What other treatments (if any) have you received for this condition prior to your visit with us? \_\_\_\_\_  
\_\_\_\_\_

Any other pertinent information? \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Patient/Guardian signature* *Date*  
All of the above information is true to the best of my knowledge

\_\_\_\_\_  
*IF not signed by Patient, Guardian Name* *Relationship to the patient*  
*If the patient is a minor or not legally competent, the parent or legal guardian must sign this document for the patient.*