

**WELCOME TO OUR OFFICE**

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**SURGICAL & ORTHOPEDIC  
MANAGEMENT OF FOOT DISORDERS**

Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Race  Not Specified  American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  White

Ethnicity  Not Hispanic or Latino  Hispanic or Latino

Due to Meaningful Use, we are required to have this information in your chart. Thank You!

Name of Spouse or Parent \_\_\_\_\_

Next of Kin/Emergency Contact (name and phone) \_\_\_\_\_

How were you referred to the office? Patient \_\_\_\_\_ Doctor's Office \_\_\_\_\_ Other \_\_\_\_\_

Family Doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_ Other (if checked above) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_ Position \_\_\_\_\_

Is this condition work related?  Yes  No Did this injury occur at school?  Yes  No

Is this condition auto related?  Yes  No Injury or Trauma?  Yes  No

**INSURANCE INFORMATION**

Type of Insurance \_\_\_\_\_ Policyholder \_\_\_\_\_

Policyholder Birth date \_\_\_\_\_ Policyholder Soc. Sec. No. \_\_\_\_\_

Policyholder Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Policyholder Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Contact & Phone Number \_\_\_\_\_

Name: \_\_\_\_\_ Patient's Age: \_\_\_\_\_ Date: \_\_\_\_\_

**CHIEF COMPLAINT** - What brought you to the doctor today?

\_\_\_\_\_

Is this condition work related?  Yes  No Did this injury occur at school?  Yes  No

Is this condition auto related?  Yes  No Injury or Trauma?  Yes  No

Date of Injury: \_\_\_\_\_

**Type of Problem**

- Corns, Callous, Nails       Fracture/Sprains       Warts, Tumors       Bunions, Hammertoes
- Diabetic Foot Care       Ingrown Nail       Ankle Pain       Neuroma or Nerve Pain
- Other       Injury       Numbness

When did the pain start? \_\_\_\_\_ Describe Pain. \_\_\_\_\_

Where does it hurt? \_\_\_\_\_ When does it hurt? \_\_\_\_\_

Previous episodes? \_\_\_\_\_ Previous treatment and response? \_\_\_\_\_

\_\_\_\_\_

**Past Medical History** Do you have a history of any of the following?

- Hypertension       Diabetes       Stroke       Nervousness       Tumors
- Heart/Circulation Trouble       Hypoglycemia       Emphysema       Epilepsy       Cancer
- Glaucoma       Kidney Disease       Ulcers       HIV/AIDS       Hepatitis
- Rheumatism/Arthritis       Liver Disease       Asthma       Anemia       Drug Abuse
- Bleeding Tendencies       Thyroid Disease       Varicose Veins       Tuberculosis       Gout
- Leg Cramps       Mitral Valve Prolapse       Osteoporosis

**Past Surgical History** Have you had any surgery before?  Yes  No

If yes, please list procedure and date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies** Do you have any allergies to medications?  Yes  No

- NSAIDS       Penicillin       Sulfa       Codeine       Aspirin
- Novacaine       Anesthetics       Iodine       Adhesives       Metal or Nickel
- Environmental      Other: \_\_\_\_\_ Type of reaction \_\_\_\_\_

Are you allergic to latex products?  Yes  No

**Medications** List all prescription medications you take; include dosage and frequency. Insulin, inhaler, and patches should be included here.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all non-prescription medications you take routinely \_\_\_\_\_

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

**Social History** Marital Status \_\_\_\_\_ Children \_\_\_\_\_ Patient's Age \_\_\_\_\_

Are you or do you think you could be pregnant?  Yes  No  
 Do you or have you ever smoked?  Yes  No How Much \_\_\_\_\_  
 Do you drink alcohol?  Yes  No How Much \_\_\_\_\_  
 What type of job do you have? \_\_\_\_\_

**Family History** List illnesses or health issues.

In whom:

Father \_\_\_\_\_ Mother \_\_\_\_\_

Siblings \_\_\_\_\_ Children \_\_\_\_\_

**Review of Systems** Please check if you have problems with any of the following**CONSTITUTIONAL**

- Fever  
 Weight loss  
 Lethargy

**GENITOURINARY**

- Frequency  
 Blood in urine  
 Abnormal urine color  
 Painful urination  
 Awaken to urinate  
 Unable to fully empty bladder  
 Incontinence

**NEUROLOGICAL**

- Headache  
 Fainting  
 Dizziness  
 Memory loss  
 Numbness

**ENDOCRINE**

- Night sweats  
 Thyroid disease  
 Diabetes  
 Heat/Cold intolerance  
 Frequent urination  
 Frequent thirst

**CARDIOVASCULAR**

- Shortness of breath  
 Chest pain (angina)  
 Heart palpitations  
 Heart attack  
 Stroke  
 Cold extremities  
 Hypertension  
 CHF

**MUSCULOSKELETAL**

- Pain -  
 Muscles  Neck  
 Back  Hips  
 Knees  Ankles  Feet  
 Limited range of motion  
 Limited strength  
 Arthritis  
 Gout

**INTEGUMENTARY**

- Rash  
 Itching  
 Dry Skin  
 Toenail/Fingernail changes

EARS \_\_\_\_\_

Immunizations Up-to-date \_\_\_\_\_

**GASTROINTESTINAL**

- Pain  
 Diarrhea  
 Constipation  
 Blood in stool/dark stool  
 Mucus in stool  
 Nausea  
 Vomiting  
 Vomit blood  
 Heartburn  
 Change in stool  
 Food intolerance  
 Loss of appetite  
 Yellow eyes or skin

**HEMATOLOGIC/LYMPHATIC**

- Easy bruising  
 Anemia  
 Blood abnormalities  
 Blood thinners  
 Lymph node enlargement

EYES \_\_\_\_\_

NOSE \_\_\_\_\_

THROAT \_\_\_\_\_

*Unmarked box indicates that the patient denies this problem.***Physician Review** \_\_\_\_\_ **Date** \_\_\_\_\_