Name:____ DOB:_____________ Date:____________

Current Medications: Name	Dose: (ex mg/mL)	Route: (oral)	Frequency: (how often)
______________________________	_________________	___________	___________________
______________________________	_________________	___________	___________________
______________________________	_________________	___________	___________________
______________________________	_________________	___________	___________________

Drug Allergies: ____

Other Allergies: ____

Pharmacy (name/street/zip code): ____

Height: _________ Weight: _________ Shoe Size: _________ Diabetic? Yes/No How Long: ________

Personal Medical History:

◻ Congestive Heart Failure	◻ Bleed/Bruise Easily
◻ Blood Clots	◻ Osteoarthritis
◻ High Blood Pressure	◻ Gout
◻ Heart Attack	◻ Rheumatoid Arthritis
◻ Stroke	◻ Alzheimer's
◻ Irregular Heart Beat	◻ Seizures
◻ Cancer	◻ Aneurysm
◻ Diabetes Type I ___ type II ____	◻ Pulmonary Embolism
◻ Hypothyroidism	◻ COPD
◻ Hyperthyroidism	◻ Asthma
◻ Autism	◻ Emphysema
◻ Cystic Fibrosis	◻ Sleep Apnea
◻ GI Bleed	◻ Mental Illness
◻ Stomach/Bowel Problems	◻ Depression
◻ Kidney Disease/ Dialysis	Suicidal thoughts? Yes / No
◻ HIV/ AIDS Anemia	◻ Alcohol/ Drug Addiction
◻ Hepatitis __A __B __ C	◻ Other

Family History: M (Mother) / F (Father)

M / F Anesthesia Problems	M / F Heart Problems
M / F Arthritis	M / F Neurological Disorder
M / F Cancer	M / F Respiratory Disorder
M / F Diabetes	M / F Seizures

Surgical History: (please list procedure and the year it was performed)

____

____

____

Name: ____ Date:______________________

Yearly Health Maintenance: Circle the ones that you have had performed

Flu Vaccine	Colonoscopy (50+)	Pneumonia Vaccine (75+)	Woman (23+) Pap Smear	Woman (41+) Mammogram	Men (40+) Prostate Exam	Diabetic Retinal Eye Exam

Do you Drink Alcohol? Yes / No How Much: _______________

Do you smoke? Yes / No / Former How much? ____________ How many Years?________________

Occupation: ____

What is the main reason for seeing one of our physicians today? ______________________________

Duration of Pain? ______________ Symptoms: ____

Is this related to an injury? Yes / No If so please describe:_________________________________

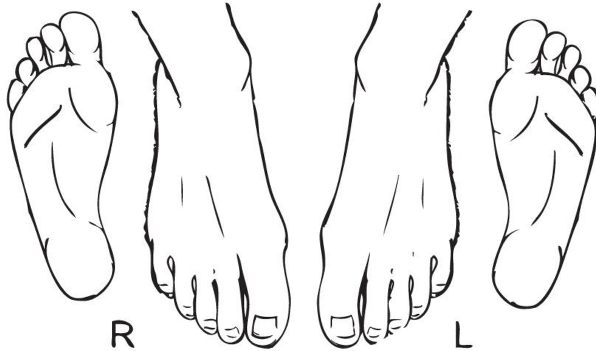
____

Please mark any of the treatments you have tried:

- ☐ Orthotics Custom / OTC inserts
- ☐ Physical Therapy
- ☐ Anti-inflammatory Medications
- ☐ Braces
- ☐ Injections
- ☐ Seeing another doctor
- ☐ Prior Surgery
- ☐ No Treatment
- ☐ Other Treatment___________________

____

Please mark on the diagram where you are experiencing pain and/or symptoms



Please Read and Sign:

The above information is correct to the best of my knowledge. I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Clintonville/Dublin Foot & Ankle. My insurance company may not cover my charges for the following reasons: I did not bring a referral for this care, the referral did not arrive in time for the visit, my insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/ co pay. The doctors and staff of Clintonville/ Dublin Foot & Ankle will file my insurance deductible / copay. but I will ultimately be responsible for all charges. A fee schedule can be obtained upon request. I understand that payment is due at time of service with no insurance or for non-covered services.

____ Date:____________

Patient/Parent/Guardian Signature