InStride Salem Foot Care

Date:_____

Last Name_____ First_____ MI _____ Age_____

Social Security #_____ Sex_____ Date of Birth_____/_____/_____

Home Address _____

Street City State Zip

Home Phone (_____)_____ Marital Status: Single Married Divorced Widow

Cell Phone (_____)_____ Email_____@_____

Preferred Method for Appointment Reminders: _____Text ____EMail _____Home _____Phone

Employer_____ Work Phone (_____)_____

Name of Spouse/ Parent_____

Family Doctor_____ Last Visit_____/_____/_____

If insurance is in another's name:

Name_____ Date of Birth_____/_____/_____

How did you hear about our office? _____

**Our receptionist will make a copy of your insurance cards on the first visit. It is important that we know all of your insurance companies to properly file your claims.

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Patient Medical History

What is your foot problem today?_____
_____
_____

How long have you had this problem?_____

How severe is the discomfort? Minor (1-2) Mild (3-5) Moderate (6-8) Severe (9-10)

Past Medical History: Please Circle All That Apply

Eyes: Diabetic retinopathy
Glaucoma
Macular Degeneration

Cardiovascular: Atrial Fibrillation
Blood Clots in Legs/ DVT
Heart Attack/ MI
Congestive Heart Failure/CHF
Cardiac Stent
Open Heart Surgery/ Bypass
Heart Murmur
High Blood Pressure
Leg Bypass or Stent
Swelling of Legs/ edema
Varicose Veins

Respiratory: Asthma
COPD
Emphysema
Blood Clot in Lungs

Dermatologic: Skin Ulcers
Skin Cancer (Type_____)
MRSA Infection
Psoriasis
Thick Scars/ Keloids

Psychiatric: Anxiety
Depression
Bipolar
Dementia
Schizophrenia

Gastrointestinal: GERD/Reflux
Hepatitis (A B C D)
Irritable Bowel Syndrome
Stomach/ GI ulcer
Liver Disease

GU/ Kidney: Kidney Stones
Kidney Disease
Dialysis
Prostate Problems

Musculoskeletal: Gout
Osteoarthritis (Wear & Tear)
Rheumatoid Arthritis
Fibromyalgia
Bulging Discs in Back
Hip Replacement
Knee Replacement

Endocrine: Diabetes (Type I or II)
High Cholesterol
Thyroid Problem
Obesity

Hematologic: HIV Infection
Sickle Cell
Anemia (Type_____)

Neurologic: Multiple Sclerosis
Stroke/ CVA
Seizures/ Epilepsy
Parkinson's Disease

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Medical History: Page 2

Please List Any medical problems not circled on first page:_____
_____
_____
_____

Have You Had the Following Surgeries?

Appendectomy
Bunionectomy: Right/ Left
C- section
Cataracts: Right/ Left/ Both
Tubal Ligation
Hysterectomy
Prostate Surgery
Kidney Stones
Tonsillectomy

Cardiac Stent
Cardiac Bypass (CABG)
Knee Arthroscopy
Knee Replacement (Right/ Left)
Hip replacement (Right/ Left)
Back Surgery (Disc/ Fusion)
Ankle Fracture/ Surgery
Hammertoe surgery
Heel Spur Surgery

Please list any other surgeries_____

Please list ALL medications you take_____
_____
_____
_____
_____
_____
_____
_____

Please list any **drug allergies**: Penicillin Sulfa Local Anesthetics Iodine Aspirin
Others:_____

Which Pharmacy do you use?_____

Do you smoke or use tobacco? _____ How much?_____ For how many years?_____

Do you drink alcohol?_____ How often? Rare Social Moderate Heavy

Do you use any recreational drugs?_____What type?_____ How often?_____