As a new patient, we need the following information provided with this form.

**Photo Identification**
**Insurance Card**
**Medication List**

Be sure to print **CLEARLY**, and use **BLACK** ink only.

DUNNELLON PODIATRY
EXCELLENCE IN FOOT AND ANKLE CARE

LAST FIRST MIDDLE

ADDRESS

CITY STATE ZIP

HOME PHONE WORK/CELL DOB AGE

SOC. SEC. NO. SEX RACE

SINGLE MARRIED SEPARATED DIVORCED WIDOWED
MARITAL STATUS (CIRCLE ONE)

PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE)

CITY STATE ZIP

EMERGENCY CONTACT NAME (NOT AT SAME ADDRESS) PHONE NUMBER

EMAIL ADDRESS

EMPLOYER/SCHOOL

ADDRESS

CITY STATE ZIP

OCCUPATION

EMPLOYER PHONE NUMBER

Is your overall health status:
POOR FAIR
GOOD EXCELLENT
(CIRCLE ONE)

HEIGHT WEIGHT

## PATIENTS PHYSICIANS

**FAMILY/PRIMARY**

PHYSICIANS NAME PHONE NUMBER CITY — **REFERRAL** [Y] [N] — **SENT OR CAME IN FOR:** [2ND OPINION] [SURG EVAL] [CONSULT]

**SPECIALIST**

PHYSICIANS NAME PHONE NUMBER CITY — **REFERRAL** [Y] [N] — **SENT OR CAME IN FOR:** [2ND OPINION] [SURG EVAL] [CONSULT]

**OTHER PODIATRIST**

PHYSICIANS NAME PHONE NUMBER CITY — **REFERRAL** [Y] [N] — **SENT OR CAME IN FOR:** [2ND OPINION] [SURG EVAL] [CONSULT]

**I WAS REFERRED BY** _____ [CURRENT/PAST PATIENT] [DOCTOR] [NURSE] [HOSPITAL]
**I SAW YOUR NAME IN** _____ [INSURANCE PROVIDER LIST] [YELLOW PAGES] [RADIO] [NEWSPAPER]
[DR. LECTURE] [BILLBOARD] [FLORIDA GREETING SERVICE INC.]

What problem are you currently having with your foot, ankle, or leg? _____

_____

_____

When did the problem start? _____

How would you rate the pain on a scale 1-10, 10 being the worst.

1 2 3 4 5 6 7 8 9 10

Is your pain (please circle one): **Mild** **Moderate** **Severe**

**Please circle all of the following that describes your pain:**

ACHING BURNING CONSTANT CRAMPING DISABLING
EXCRUCIATING INTERMITTENT/INCONSISTENT IMPROVING
PRESSURE RADIATING/SHOOTING INTO THE TOES OR UP THE LEG
TENDER TOLERABLE WORSE IN MORNING WORSE AT NIGHT
WORSENING FEELS LIKE YOUR WALKING ON A PEBBLE OR ROCK

Other words to describe your pain: _____

_____

_____

Does anything make it feel better, if so, what?:_____

_____

_____

Is this condition related to an injury or trauma?_____

_____

_____

Do you smoke now? [Y] [N] If yes, how many packs per day?

1 2 3 4 5 6 7 8 9 10+

Did you ever smoke? If yes, for how long and how many packs per day?

_____

Do you drink alcoholic beverages? [Y] [N] How many per week?

1 2 3 4 5 6 7 8 9 10+

Do you use any recreational drugs? [Y] [N]

What percentage of your hours awake are you on your feet?

10% 40% 60% 80% 100%

**PLEASE CIRCLE YOUR RESPONSE TO THE QUESTIONS BELOW:**

| **Question** | [Y] [N] |
|---|---|
| Are you under active chemotherapy? | [Y] [N] |
| Do you have joint implants? | [Y] [N] |
| Have you ever had vascular graft surgery? | [Y] [N] |
| Do you have history of gastro-esophogeal reflux disease? | [Y] [N] |
| Can you tolerate anti-inflammatory medication such as Motrin or Aleve? | [Y] [N] |

Do you have any allergies? if so, please list and describe the reaction you have/had: _____

_____

_____

_____

Medication (Please list all medications or provide front desk with a list for copying):_____

_____

_____

_____

_____

_____

_____

List any surgeries you have had:

_____

_____

_____

_____

_____

_____

## Has anyone in your family had one of the following conditions?

| | | |
|---|---|---|
| Diabetes | [Y] | [N] |
| Arthritis | [Y] | [N] |
| Stroke | [Y] | [N] |
| Cancer | [Y] | [N] |
| Heart Attack | [Y] | [N] |
| High Blood Pressure | [Y] | [N] |
| Coronary Artery Disease | [Y] | [N] |
| Foot Problems | [Y] | [N] |

## Have you recently had any of the following? Mark yes if you have previously had these.

| | | |
|---|---|---|
| Chills | [Y] | [N] |
| Fever | [Y] | [N] |
| Headache | [Y] | [N] |
| Nausea | [Y] | [N] |
| Vomiting | [Y] | [N] |
| Dizziness | [Y] | [N] |
| Decreased appetite | [Y] | [N] |
| Blood in your stools | [Y] | [N] |
| Heartburn | [Y] | [N] |
| Ulcers | [Y] | [N] |
| Cough | [Y] | [N] |
| Difficulty breathing | [Y] | [N] |
| Shortness of breath | [Y] | [N] |
| Painful urination | [Y] | [N] |
| Increase in frequency of urination | [Y] | [N] |

## Have you recently had any of the following? Mark yes if you have previously had these.

| | | |
|---|---|---|
| Bruise Easily | [Y] | [N] |
| Abnormal bleeding | [Y] | [N] |
| Swollen groin lymph nodes | [Y] | [N] |
| Athletes Foot | [Y] | [N] |
| Blisters | [Y] | [N] |
| Dermatitis | [Y] | [N] |
| Eczema | [Y] | [N] |
| Excessive scar tissue after cuts or surgery | [Y] | [N] |
| Hives | [Y] | [N] |
| Non-healing wounds | [Y] | [N] |
| Psoriasis | [Y] | [N] |
| Skin cancers | [Y] | [N] |
| Toenail problems | [Y] | [N] |
| Balance problems | [Y] | [N] |
| Difficulty walking | [Y] | [N] |
| Numbness | [Y] | [N] |
| Paralysis | [Y] | [N] |
| Tingling | [Y] | [N] |
| Tremors | [Y] | [N] |
| Weakness | [Y] | [N] |
| Uncontrolled movements | [Y] | [N] |

I hereby give permission for Stacy L. Witfill DPM to examine, administer treatment and perform tests as may be necessary in the diagnosis and treatment of my foot, ankle, or leg condition.

SIGNATURE DATE

## Please check off all conditions that apply to your medical history:

- ☐ ACNE
- ☐ ATTENTION DEFICIT DISORDER
- ☐ ALLERGIES
- ☐ ANGINA
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ANXIETY/DEPRESSION
- ☐ ARTHRITIS DEGENERATIVE
- ☐ ARTHRITIS RHEUMATOID
- ☐ ASTHMA
- ☐ ARTIAL FIBRILLATION
- ☐ BACK PAIN
- ☐ BASAL CELL CANCER
- ☐ BENIGN PROSTATIC
- ☐ HYPERPLASIA
- ☐ BARRETT'S ESOPHAGUS
- ☐ BI-POLAR DISORDER
- ☐ CANCER
- ☐ CONGESTIVE HEART FAILURE
- ☐ CARPAL TUNNEL SYNDROME
- ☐ CARDIAC (HEART) MURMUR
- ☐ COLITIS
- ☐ COLON POLYPS
- ☐ CHRONIC KIDNEY DISEASE
- ☐ CHRONIC PAIN SYNDROME
- ☐ CHRONIC SINUSITIS
- ☐ CORONARY ARTERY DISEASE
- ☐ COPD
- ☐ CHROHN'S DISEASE
- ☐ CVA(STROKE)
- ☐ DEPRESSION
- ☐ DIVERTICULITIS
- ☐ DIABETES
- ☐ ECZEMA
- ☐ ENDOMETRIOSIS
- ☐ ESOPHAGEAL EFFLUX
- ☐ FIBROMYALGIA
- ☐ FIBROIDS
- ☐ GOUT
- ☐ GENITAL HERPES
- ☐ HEMORRHOIDS
- ☐ GASTOESOPHAGEAL REFLUX
- ☐ DISEASE
- ☐ HIV/AIDS
- ☐ HIATAL HERNIA
- ☐ HYPERLIPIDEMIA(HIGH
- ☐ CHOLESTEROL)
- ☐ HYPERTENSION(HIGH BLOOD
- ☐ PRESS)
- ☐ HYPOTHYROIDISM
- ☐ IRRITABLE BOWL SYNDROME
- ☐ INSOMNIA
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LUNG DISEASE
- ☐ LIVER FUNCTION TEST
- ☐ ABNORMALITIES
- ☐ MIGRAINES
- ☐ MITRAL VALVE PROLAPSE
- ☐ NEUROPATHY
- ☐ OBESITY
- ☐ OBSTRUCTIVE SLEEP APNEA
- ☐ OSTEOPOROSIS
- ☐ OSTEOPENIA
- ☐ PEPTIC ULCER DISEASE
- ☐ PERIPHERAL VASCULAR
- ☐ DISEASE
- ☐ POLYCYSTIC OVARIAN
- ☐ SYNDROME
- ☐ RESTLESS LEG SYNDROME
- ☐ SQUAMOUS CELL CANCER
- ☐ TUBERCULOSIS
- ☐ THYROID DISEASE
- ☐ ULCERATIVE COLITIS
- ☐ VARICOSE VEINS

- ☐ ABDOMINOPLASTY (Tummy Tuck)
- ☐ ANGIOPLASTY
- ☐ ANKLE SURGERY
- ☐ APPENDECTOMY
- ☐ BLOOD TRANSFUSION
- ☐ BREAST BIOPSY
- ☐ BREAST SURGERY
- ☐ TUBAL LIGATION
- ☐ CABG (HEART BYPASS)
- ☐ CARDIAC
- ☐ CATHETERIZATION
- ☐ CARPAL TUNNEL
- ☐ CATARACT SURGERY
- ☐ CESAREAN SECTION
- ☐ CHOLECYSTECTOMY (Gall Bladder)
- ☐ COLONOSCOPY
- ☐ COSMETIC
- ☐ EYE
- ☐ FOOT SURGERY
- ☐ GASTRIC BYPASS
- ☐ HAND SURGERY
- ☐ HERNIA
- ☐ HYSTERECTOMY
- ☐ JOINT REPLACEMENT
- ☐ KNEE
- ☐ LASIK
- ☐ NASAL SEPTUM
- ☐ RHINOPLASTY
- ☐ SHOULDER
- ☐ SINUS
- ☐ SPLENECTOMY
- ☐ SPINAL
- ☐ TONSILLECTOMY
- ☐ THYROID