Date:_________________________

Save Your Soles Podiatry

Name: ____ Birth Date: ______________________________

Address: ____ City/State_____________________ Zip _____________

Telephone: Home: ________________________________ Cell: __________________________ (Circle preferred primary contact number)

What is your chief foot complaint? ____

____

Have your feet ever been X-rayed? ___________When? ____

Have you had previous foot care? ____________ When? ____

What is your occupation? ____

Marital status (circle one) Married   Single   Divorced   Widow/Widower

Are you presently suffering from any of the following:

- ____ Diabetes. If yes, how long? _______________
- ____ Kidney Disease
- _____ Heart Disease
- ____ Liver Problems
- _____ Gout
- ____ Circulation Issues
- _____ Epilepsy
- ___ Other: ____

Do you have artificial joints or valves? _____________

Are you allergic to any medications? ___ Yes   ___ No (If yes, please list them) _______________________________

____

Please list all medication which you are presently taking: ____

____

____

Have you been in the hospital during the past few years? ____ Yes   ____ No   If yes, what was the reason for the hospitalization? ____

What is your shoe size? _____________________ Do you exercise? _____ Yes   _____ No

Name of personal physician: ____Phone Number: ______________________

Emergency Contact: ____

Phone Number: _____________________ Relationship: ____

Who referred you to this office? ____

Please bring picture ID and medical insurance cards on first visit