

University Foot Associates

1. PATIENT IDENTIFICATION AND CONTACT INFORMATION

First Name:		MI:	Last Name:		Preferred Nickname	
Address:					City / Zip	
Social Security No.		Sex: M / F	Date of Birth: / /		Shoe Size:	
Married Single Divorced			Weight:		Employer:	
Phone Numbers:				Emergency Contact:		
Home: () _____				Name: _____		
Work: () _____				Work #: () _____ - _____		
Cell: () _____				Evening #/Cell: () _____ - _____		
Preferred Pharmacy:						
Name: _____			Street: _____			
City: _____			Phone: () _____ - _____			

2. REFERRAL SOURCE

How did you hear about us? _____ Yellow Pages _____ MD Referral _____ Passing By _____ Insurance _____ Brochure Other: _____

3. PATIENTS DOCTORS

Physicians name:	Phone Number:	City:	Referred me:
Primary Physician: _____			Y / N
Specialist: _____			Y / N

4. PATIENT MEDICAL HISTORY

# Of Childbirths: _____	Are you currently pregnant? Y / N
Are you slow to heal after cuts? Y / N	Any abnormal bruising/scarring? Y / N
Do you smoke? Y / N Number of packs a day? _____ Number of years _____	
Did you ever smoke? Y / N Number of packs a day? _____ Number of years? _____	
If you quit, when did you do so? _____	
Alcoholic Beverages? None Rarely Moderately Daily Quit	