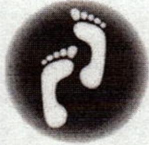

LAKE IN THE HILLS PODIATRY

PLEASE PRINT

Date ______________________ Patient Name ____

LAST FIRST MIDDLE INITIAL

ADRESS; CITY; STATE; ZIP____

BIRTHDATE______________________________ SEX: ☐ M ☐ F AGE _________

EMAIL: ____

_______ MARRIED _______ WIDOWED _______ SINGLE _______ MINOR

_______ SEPARATED _______ DIVORCED _______ PARTNERED

PATIENT EMPLOYER AND/OR SCHOOL ____

EMPLOYER AND/OR SCHOOL ADDRESS ____

EMPLOYER AND/OR SCHOOL PHONE ____

PHONE NUMBERS:

PRIMARY PHONE # ______________________________ ALTERNATE PHONE # ______________________________

IN CASE OF EMERGENCY, CONTACT

NAME: ______________________________ RELATIONSHIP ______________________________

PHONE # ______________________________ ALTERNATE # ______________________________

PODIATRIC HISTORY

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED?

____

HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? _____ YES ____ NO IF YES PLEASE LIST, NAME__________________

LAST VISIT _________________ IS THERE ANY PERSONAL OR FAMILY HISTORY OF DIABETES? ______YES _______ NO

YOUR OCCUPATION ______________________ CIGARETTE/TOBACCO USE __________ YEARS SMOKED ____________

ATHLETIC ACTIVITIES IN WHICH YOU PARTICIPATE (PLEASE LIST AND INDICATE FREQUENCY) _______________________

____

PLEASE INDICATE WHICH FOOT PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST.

_______ATHLETE'S FOOT _______CORNS/CALLUSES ________FLAT FEET

_______ HEEL PAIN _______ BUNIONS

_______ SWELLING IN ANKLES OR FEET _______ PLANTAR WARTS

_______ INGROWN TOENAILS _______ANKLE PAIN

_______ NUMBNESS IN FEET OR LEGS _______CRAMPS IN FEET OR LEGS

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had ____________________

____

Hospitalization other than for the surgeries listed ____________________

____

Family Physician ____________________ Last visit date ____________

Are you now, or have you been under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain ____________________

MEDICATIONS (If you need more room, write on a separate sheet of paper)
Include prescriptions with milligrams, over the counter and vitamins ____________________

____

____

____

Pharmacy Name/location: ____________________

Pharmacy Phone # ____________________

ALLERGIES: ____________________

CONSENT FOR TREATMENT

I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY. I ALSO AGREE TO ALLOW DR. EMO BONAMINIO TO USE THE HEALTHCARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THEIR INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

THIS CONSENT WILL REMAIN ACTIVE AS LONG AS I AM A PATIENT OF DR EMO BONAMINIO AT LAKE IN THE HILLS PODIATRY.

____________________ DATE: ____________

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE