PROFESSIONAL
Foot & Ankle Centers
DAVISON • LAPEER

Mark R. Williams, DPM
Krysta A. Schroeder, DPM
Jason P. Weslosky, DPM

MEDICAL HISTORY FORM

Name: _____ Date:_____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Occupation/Employer _____

Pharmacy _____ Pharmacy City _____

Primary Care Physician: _____ Date of Last Visit: _____

Do you have Diabetes? ☐Y☐N If so, do you wear Diabetic shoes? ☐Y ☐N

Doctor Managing Diabetes: _____ Date of Last Visit: _____

How did you learn about our office? Doctor Referral (name) _____

Friend _____ Family _____

☐ Hospital (ER) ☐ Website ☐ Phone book ☐ Sign ☐ Previous Patient

Chief Complaint (Specific concern you would like addressed by your doctor today?) _____

_____

When did your condition first begin? #____ Days Ago #____ Weeks #____ Months #____ Years Ago

Was it related to an injury? ☐No ☐Yes What Type?_____

Which activities make your condition worse? *(Please check answers)*

☐Standing up ☐Standing up at the end of the day ☐Walking ☐ Running ☐ Athletics

☐Uneven ground ☐Certain Shoes ☐Work ☐Exercise ☐Lifting ☐Walking Barefoot ☐Other:_____

Which of the following treatments have you tried? *(Please circle answers)*

☐Anti-inflammatory medications ☐Physical Therapy ☐Stretching ☐Shoe Modifications ☐Padding ☐Inserts

☐Bracing ☐Cortisone injections ☐Surgery ☐Aspirin ☐Tylenol ☐Pain Medications ☐Soaks

☐Ice ☐Heat ☐Rest ☐Topical medications ☐Other: _____

Does anything make your condition better? ☐No ☐Yes If so, Explain: _____

Mark the scale to indicate your average pain due to your foot and ankle condition.

0	1	2	3	4	5	6	7	8	9	10
No Pain										*Worst Pain Imaginable*

Has any other physician/person treated this condition? ☐ No ☐ Yes, whom & when: _____

Have you ever been to a podiatrist before? ☐ No ☐ Yes, who: _____

***** *Don't Forget to Complete the Other Side* *****

DAVISON: 605 South State Road • Davison, MI 48423 • (P) 810.653.9060 • (F) 810.658.2248
LAPEER: 1390 North Main Street • Lapeer, MI 48446 • (P) 810.664.1250 • (F) 810.664.0315
ProfessionalFoot.com

Past Medical History *(Please check all that apply)*

- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer/Type _____
- ☐ Chronic Back Pain
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes
- ☐ DVT (blood clot in leg)
- ☐ Emphysema/COPD
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Beat Irregular
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Heart Pacemaker/AICD
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroid (low)
- ☐ HIV/AIDS
- ☐ Kidney Dialysis
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Mental Illness
- ☐ Multiple Sclerosis (M.S.)
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peripheral Arterial Disease (PAD of legs)
- ☐ Peripheral Neuropathy
- ☐ Phlebitis
- ☐ Psoriasis
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Raynaud's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sickle Cell Anemia/Trait
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Other _____

Medications

1. _____ 4. _____ 7. _____ 10. _____
2. _____ 5. _____ 8. _____ 11. _____
3. _____ 6. _____ 9. _____ 12. _____

Review of Systems *(Please check all items that apply currently or recently)*

1. Constitutional Symptoms	☐ Fever	☐ Chills	☐ Headache	☐ no symptoms
2. Musculoskeletal	☐ Joint Pain	☐ Joint Swelling	☐ Stiffness	☐ no symptoms
3. Integumentary (Skin)	☐ Foot Ulceration	☐ Discoloration	☐ Rash	☐ no symptoms
4. Neurological	☐ Numbness/Tingling	☐ Tremors	☐ Paralysis	☐ no symptoms
5. Cardiovascular	☐ Chest Pain/Pressure	☐ Calf Cramping	☐ Heart Palpitations	☐ no symptoms
6. Respiratory (Lungs)	☐ Shortness of Breath	☐ Wheezing	☐ Frequent Cough	☐ no symptoms
7. Endocrine	☐ Fatigue	☐ Excessive Thirst	☐ Heat Intolerance	☐ no symptoms
8. Hematologic/Lymphatic	☐ Foot or Ankle Swelling	☐ Swollen Glands	☐ Bleeding Problems	☐ no symptoms
9. Eyes	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain	☐ no symptoms
10. Ears, Nose, Throat, Mouth	☐ Hearing Loss	☐ Sore Throat	☐ Sinus Problem	☐ no symptoms
11. Gastrointestinal	☐ Nausea/Vomiting	☐ Heartburn	☐ Abdominal Pain	☐ no symptoms
12. Genitourinary	☐ Painful Urination	☐ Urinary Frequency	☐ Urine Retention	☐ no symptoms
13. Psychiatric	☐ Addiction to Alcohol	☐ Depression	☐ Anxiety	☐ no symptoms
14. Allergic/Immunologic	☐ Recent Asthma Attack	☐ Seasonal Allergies	☐	☐ no symptoms

Allergies *(Please check all that apply)*

- ☐ No Known Drug Allergies
- ☐ Adhesive Tape
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ IV Dye
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Past Surgical History *(Please check all that apply)*

- ☐ Amputation
- ☐ Angioplasty (heart stent)
- ☐ Appendectomy (removal of appendix)
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Carpal tunnel surgery
- ☐ Cholecystectomy (gall bladder)
- ☐ C-section
- ☐ Eye surgery
- ☐ Foot surgery (what?) _____
- ☐ Heart bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Knee scope
- ☐ Mastectomy
- ☐ Thyroid removal
- ☐ Tonsillectomy
- ☐ Vascular surgery
- ☐ Other _____
- ☐ Hospitalizations _____

Family History *(Please check all that apply)*

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Other_____

Social History

Do you smoke? Yes No How much? _____ How long? _____ Quit when? _____

Do you drink alcohol? Yes No How much? _____ Do you chew tobacco? Yes No

Do you use illicit drugs? (cocaine, etc.) Yes No Do you use Marijuana or THC products? Yes No

Signature of Patient/Legal Guardian_____ Date_____

Physician Signature *(Form completely reviewed)*_____ Date _____

PROFESSIONAL
Foot & Ankle Centers
DAVISON • LAPEER

Mark R. Williams, DPM
Krysta A. Schroeder, DPM
Jason P. Weslosky, DPM

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____
(First) (Middle) (Last)

Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D S.S.# _____

Address: _____
(Street) (City) (State) (Zip + 4)

Phone: _____ Cell: _____ E-Mail: _____

Primary Care Physician: _____ Date of Last Visit: _____

Spouses Name: _____ Date of Birth: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Required by Medicare *Ethnicity:* ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Hawaiian or Pacific Islander

Primary Insurance: _____ I.D. # _____

Policy Holders Name: _____ Date of Birth: _____

Policy Holders SS#: _____ Relationship to Patient: _____

Secondary Insurance: _____ I.D. # _____

Policy Holders Name: _____ Date of Birth: _____

Policy Holders SS#: _____ Relationship to Patient: _____

Is this Worker's Comp? ☐ Y ☐ N **Auto Accident?** ☐ Y ☐ N **Other Acciddent?** ☐ Y ☐ N

Complete this Section if Patient is a Minor

Responsible Party: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____

Address: _____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Professional Foot & Ankle Centers, P.C. to furnish any medical information necessary to process insurance claims for my treatment acquired in the course of the examination or hospitalization. I authorize payment of medical and/or surgical benefits to Professional Foot & Ankle Centers, P.C. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for any and all balances such as co-insurance, co-payments, and deductibles.

_____ _____
Signature of Patient/Legal Guardian *Date*

_____
Print Name