601 S. 8th Street
Brennan R. Reed, DPM Quincy, IL 62301

PERSONAL INFORMATION:

Date: _______________Patient Name:(first)____________(m)____(last)____________

Home Phone: (____)___-_____ Work Phone: (____)____-_____Cell (___)___-______

Social Security Number: ______________Home Address:______________________

Apt#:_______City:______________________ State:_________ Zip Code:__________

Gender: ☐ Male ☐ Female Birthdate: _______________ Age: ________________
Height:___________ Weight:___________ Shoe Size:_________________________
Employed by:_________________________ Occupation:______________________
Primary Physician _________________ Last visit:___________ Next visit_________
Whom may we thank for your referral: _________ ____________________________
Name of: ☐ Spouse ☐ Parent ☐ Legal Guardian minors):_______________________

HISTORY OF PRESENT CONDITION:

Nature/Location of problem: (e.g. right big toe nail hurts, left inside ankle sore)
____
Duration: (e.g. 2 weeks)______ Days _______ Weeks _______ Months _______Years
Onset: ☐ Gradual ☐ Sudden **Course:** ☐ Improving ☐ Worsening ☐ Remains Same
Relieving Factors: (e.g. rest)____
Aggravating Factors: (e.g. shoe gear)______________________________________
Treatment rendered by other physicians:____________________________________
Treatment rendered by self:____
Any other information or conditions that may be related to this problem or important:____

MEDICATIONS: Please list any and all prescription and over the counter medications:____
____
____
____***PHARMACY***:_________________

SURGICAL HISTORY: Please list all surgeries, year of procedure, and any <u>major</u> complications____
____

ALLERGIES: (if yes, please list reaction e.g. hives, stomach upset, shortness of breath)

☐ Acetaminophen _________________________
☐ Adhesive tape _________________________
☐ Aspirin ______________________________
☐ Codiene _____________________________
☐ Iodine/Betadine ________________________
☐ Keflex ______________________________
☐ Latex _______________________________
☐ Local anesthetics (e.g. Novicaine)
☐ Nubain______________________
☐ Penicillin:__ __________________
☐ Pollen/dust/mold_______________
☐ Sulfa Drugs___________________
☐ Others:______________________
☐ <u>No Known Allergies</u>

FAMILY HISTORY: List any family members who have or have had the following:

□ Cancer_____________________________
□ Diabetes ___________________________
□ HIV (AIDS)_________________________
□ Heart Attacks________________________
□ Heart Disease ______________________
□ Hepatitis ___________________________
□ Bleeding disorders ____________________
□ High blood Pressure___________________
□ Strokes ______________________________
□ Thyroid_______________________________
□ Reaction to anesthesia_______________

SOCIAL HISTORY:

(Activity Level)

Check one: □Extremely active □ Moderately active □Somewhat active □ Somewhat inactive □ Sedentary

Check any that apply: □ Job requires standing most of day □ Work on concrete flooring □ Wear work boots all day □ Run /Walk _____ Miles x ___days per week □ Climb stairs/ladders frequently □ Walk barefoot at home

Alcohol:

□ Deny □ Admit: Described as □ Recovering alcoholic □ Social □ Mild □ Moderate □ Heavy □ At bedtime

Tobacco use: Current □ yes __ packs daily □ no History of use: ____ packs daily x _____ years of use

Recreational Drugs: □ yes ________________________________ □ no

Marital status: □ Single □ Married □ Divorced □ Widowed

MEDICAL CONDITIONS: Please mark each line

	Present	Past	Never
□ Anemia	□	□	□
□ Anxiety	□	□	□
□ Arthritis	□	□	□
□ Asthma	□	□	□
□ Bladder Dysfunction	□	□	□
□ Bleeding tendencies	□	□	□
□ Cancer____________	□	□	□
□ Claudication(calf pain)	□	□	□
□ COPD	□	□	□
□ Coronary Artery Disease	□	□	□
□ DVT (blood clots)	□	□	□
□ Dementia	□	□	□
□ Depression	□	□	□
□ Diabetes x ____ years	□	□	□
□ Fibromyalgia	□	□	□
□ GERD (Acid reflux)	□	□	□
□ GI Bleeds/Ulcers	□	□	□
□ Glaucoma	□	□	□
□ Gout	□	□	□
□ Heart Conditions	□	□	□
□ Hepatitis	□	□	□
□ HIV (AIDS)	□	□	□
□ High cholesterol	□	□	□
□ High blood pressure	□	□	□
□ Heart attack	□	□	□
□ Neuropathy (numbness)	□	□	□
□ Peripheral Vasc Dz	□	□	□
□ Stroke	□	□	□
□ Sleep Apnea	□	□	□

□ Other ____

I authorize the release of any medical or other information necessary to process this claim. I certify the above information to be accurate and hold the Reed Foot Clinic and it's physicians free of any liability stemming from complications occurring as a result of misrepresentation of the above. I consent to any diagnostic testing and/or treatment deemed necessary by the physicians of this clinic to diagnose and treat my condition.

____
Signature (parent/guardian for minors)

____
Date: