InStride Family Foot Care

PATIENT INFORMATION SHEET

NAME:_____ **DATE OF BIRTH:**_____

SEX: M / F MARITAL STATUS: S M D W

ADDRESS:_____
Street or box # city or town state zip

HOME PHONE:_____ **CELL PHONE:**_____

EMPLOYER:_____ SPOUSE'S NAME:_____

EMAIL:_____ May we email you periodically? Yes No

CONTACT IN CASE OF EMERGENCY:_____

PHONE #_____ RELATIONSHIP TO PATIENT_____

HOW DID YOU HEAR ABOUT THE PRACTICE? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____

Insurance Company_____ Facebook_____ Other_____

Are you currently taking any medications: Yes No If yes, list below.

_____ _____ _____

_____ _____ _____

Allergies:_____

Pharmacy Name:_____

Do you give us permission to pull your medicine history?_____

List any surgeries you have had:_____

_____

Family History: ____Heart Disease ____Diabetes ____High Blood Pressure ____Cancer ____Other:_____

Do you smoke: Y N Packs/day/years

FAMILY DOCTOR:_____ **LAST VISIT:**_____

Please describe the reason for your visit today:_____

_____

_____ _____
Signature Date