Sheboygan Foot Care, LLC
Steven L. Wolfington, DPM, FACFAS

Welcome to our practice!

Please take a moment to complete the following questions as thoroughly as possible. This will enable us to provide you with the utmost in professional podiatric treatment. If you need any assistance in completing your forms, please do not hesitate to inquire at the front desk. We are here to make your visit a pleasant experience.

Patient Information:

Full Name: _____ Male / Female
Address: _____City: _____Zip: _____
Phone: Home ( ) _____ Work ( ) _____
Date of Birth : _____ Age: _____ SS# _____-_____-_____
Marital Status: _____ Email: _____
Employer: _____ Occupation: _____

How were you referred to our office? _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____
Phone: Home: ( ) _____ Work ( ) _____

Responsible Party (if other than patient):

Full Name: _____Marital Status: _____
Address: _____City:_____Zip: _____

Insurance Information:

Carrier: _____
Name of Insured (If other than patient): _____
Address: _____City:_____Zip: _____
Phone: Home ( ) _____ Work ( ) _____
Date of Birth : _____ Age: _____ SS# _____-_____-_____
Employer: _____ Occupation: _____

Primary Care Physician or Medical Doctor:

Name: _____ Phone: ( ) _____
Last Visit Date: _____
Pharmacy Name: _____

I, _____, acknowledge that I have received the written Notice of Privacy Practices from Sheboygan Foot Care, LLC.

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Sheboygan Foot Care, LLC. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services plus any lab fees generated outside of the office. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of the signature on all insurance submissions.

Signature:_____ **Date:**_____

Sheboygan Foot Care, LLC
Medical History

Name:_____Date:_____
Birth Date:_____ Age:_____ Sex: M F Height:_____Weight:_____
Shoe Size:_____ Type of Shoe Most Worn:_____ Activity Level: High Average Low

Please Circle'Y'es or 'N'o or 'F' for family history to indicate if you have or have had any of the following:

AIDS/HIV	Y	N	F	Hepatitis	Y	N	F
Anemia/'Low Blood'	Y	N	F	High Blood Pressure	Y	N	F
Arthritis/'Old Age'	Y	N	F	Kidney Stones	Y	N	F
Arthritis/Rheumatoid	Y	N	F	Mitral Valve Prolapse	Y	N	F
Asthma	Y	N	F	Multiple Sclerosis	Y	N	F
Bleeding Disorders	Y	N	F	Phlebitis	Y	N	F
Blood Clots/Phlebitis	Y	N	F	Radiation Treatment	Y	N	F
Cancer	Y	N	F	Rheumatic Fever	Y	N	F
Chemical Dependency	Y	N	F	Stomach Ulcer/Reflux	Y	N	F
Congestive Heart Failure	Y	N	F	Stroke	Y	N	F
Coronary Artery Disease	Y	N	F	Thyroid Disease	Y	N	F
Diabetes	Y	N	F	Tuberculosis	Y	N	F
Epilepsy/Seizure Disorder	Y	N	F				
Fibromyalgia	Y	N	F	For Women:			
Gout	Y	N	F	Are you Pregnant?	Y	N	
Headaches	Y	N	F	Are you nursing?	Y	N	
Heart Attack	Y	N	F	Other_____			

MEDICATIONS: Include Prescription, Over the Counter Medications and Vitamins:

_____
_____
_____
_____

ALLERGIES: Indicate if you have an Allergy to the following:

Adhesive Tape	Y N	Intravenous Dyes	Y N	Seafood/Shellfish	Y N
Aspirin	Y N	Latex Rubber	Y N	Seasonal	Y N
Codeine	Y N	Local Anesthetics	Y N	Soy/Egg Products	Y N
Demerol	Y N	Penicillin	Y N	Sulfa Drugs	Y N

Other:_____

SURGICAL HISTORY: Please circle 'Y'es or 'N'o if you have ever had any of the following:

Appendectomy	Y	N	Mastectomy/Lumpectomy	Y	N
Cataracts/Eye Surgery	Y	N	Reconstructive/Plastic Surgery	Y	N
Gall Bladder	Y	N	Surgery on Lungs	Y	N
Heart Bypass	Y	N	Surgery for Ulcers	Y	N
Heart Valve Replacement	Y	N	Surgical Repair of Broken Bones	Y	N
Hip/Knee Replacement	Y	N	Transplant (Organ)	Y	N
Hysterectomy	Y	N	Tubal Ligation	Y	N

Have you ever healed with thick, disfigured, or Keloid scars?	Y	N
Have you ever had any problems with slow healing of surgical incisions?	Y	N
Have you ever had a blood transfusion?	Y	N
Have you ever had any problems with anesthesia in the past?	Y	N
Is there a history in your family of malignant hypothermia with anesthesia?	Y	N
Do you routinely take aspirin, over-the-counter anti-inflammatory, or anticoagulants?	Y	N

Patient/Guardian Signature:_____Date:_____

Sheboygan Foot Care, LLC

Name:_____**D.O.B**_____**Date:**_____

HISTORY OF FOOT PROBLEMS:

What specific problem with your foot/feet brings you to our office today? _____

_____

If the problem is related to an injury or accident, please describe what happened:_____

_____

How would you describe the pain/discomfort on a scale of 1 to 10, with 1 being the least and 10 the worst?
Please Circle: 1 2 3 4 5 6 7 8 9 10

Where on your foot/feet is the pain located?_____

When did this problem first start?_____ How long have you had this problem?_____

Did this problem develop over a period of time, or was it quite sudden?_____

Has this problem stayed the same, improved, or worsened since it started?_____

What are some things that you do that make the problem worse?_____

_____

Is the problem worse in the morning or the end of the day?_____

Have you seen a different physician for this problem? Y N If yes, what treatments were done?_____

_____

Have you taken any over-the-counter or prescribed medications for your foot? Y N If yes, which ones?____

_____

Have the medications provided any relief? Y N

Has this problem affected your ability to work, enjoy your sports/hobbies or carry on your usual daily routine?
Y N Please explain:_____

Have you ever had foot surgery? Y N If yes, please tell us what was done and which foot/feet were involved:_____

REVIEW OF SYMPTOMS

Please indicate any personal history below:

Chills/Fever	Y N	Fatigue	Y N	Chest Pain/Angina	Y N
Cold Intolerance	Y N	Sleep Apnea	Y N	Hormone Problem	Y N
Chronic Sinus Problems	Y N	Rash or Itching	Y N	Dermatitis (dry skin)	Y N
Swollen Glands in Neck	Y N	Blurred/Double Vision	Y N	Wear Glasses/Contacts	Y N
Blood in Urine	Y N	Frequent Urination	Y N	Burning/painful urination	Y N
Abdominal Pain	Y N	Constipation	Y N	Frequent Diarrhea	Y N
Difficulty Walking	Y N	Back Pain	Y N	Joint Stiffness/Swelling	Y N
Shortness of Breath	Y N	Insomnia	Y N	Memory Loss/Confusion	Y N
Convulsions/Seizures	Y N	Tremors	Y N	Slow Healing Cuts	Y N
Bleeding/ Bruising Tendencies	Y N				

PERSONAL HISTORY: Please Circle 'Y'es or 'N'o

Do you use tobacco products Y N Do you drink alcohol products? Y N

Chewing Smoking

Packs/Day_____ Years Smoked_____ How much do you drink?_____

How often do you drink?_____

Do you currently use, or have used in the past, any substance or any prescription narcotic in excess that may injure or may have contributed to any health problems? Y N

Do you exercise? Regularly Rarely Never

To the best of my knowledge, the questions answered in this form and the Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor/staff of any changes in my medical status. I also authorize the healthcare staff to perform the necessary service I may need.

Patient/Guardian Signature:_____Date:_____