MARTIN C. HARRIS, DPM – BENJAMIN J KNABEL,DPM

NAME:_____AGE:_____DATE OF BIRTH:_____ ☐FEMALE ☐MALE
HEIGHT:_____WEIGHT:_____EMAIL:_____
PHARMACY NAME AND CITY:_____
EMERGENCY CONTACT NUMBER OTHER THAN HOME NUMBER:_____

MEDICAL INFORMATION

DESCRIBE YOUR FOOT PROBLEM:_____
LENGTH OF TIME IT HAS BEEN BOTHERING YOU:_____
PREVIOUS FOOT/ANKLE PROBLEMS:_____
ARE YOU PREGNANT?_____REFERRED BY:_____
MEDICATION ALLERGIES:_____
MEDICATIONS:_____

PAST MEDICAL HISTORY

☐ ANEMIA
☐ ANXIETY
☐ ASTHMA
☐ ARTHRITIS
☐ BLADDER DYSFUNCTION
☐ BLEEDING DISORDER
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CIRCULATION PROBLEMS
☐ DEPRESSION
☐ DIABETES
☐ FIBROMYALGIA
☐ FREQUENT INFECTION
☐ GERD/REFLUX
☐ GLAUCOMA
☐ GOUT
☐ HEALING DIFFICULTIES
☐ HEART ATTACK
☐ HEART DISEASE
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV/AIDS
☐ INCREASED CHOLESTEROL
☐ INTESTINAL PROBLEMS
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ LUNGS DISEASE
☐ MACULAR DEGENERATION
☐ MIGRAINES
☐ MULTIPLE SCLEROSIS
☐ NEUROPATHY
☐ RHEUMATIC FEVER
☐ SEASONAL ALLERGIES
☐ SEIZURE DISORDER
☐ SKIN PROBLEMS
☐ STOMACH ULCERS
☐ THYROID DYSFUNCTION
☐ TUBERCULOSIS

PREVIOUS SURGERIES:_____

FAMILY (BLOOD RELATIVE) HISTORY

☐ ARTHRITIS
☐ BLEEDING DISORDER
☐ BUNION
☐ CANCER
☐ DIABETES
☐ FLAT FEET
☐ HAMMERTOE
☐ HEART DISEASE
☐ NEUROLOGICAL DISORDER
☐ STROKE

SOCIAL HISTORY

DO YOU SMOKE? ☐NO ☐YES #OF PACKS PER DAY_____WHEN DID YOU QUIT_____
DO YOU DRINK? ☐NO ☐YES # OF DRINKS PER WEEK _____
DO YOU HAVE A HISTORY OF ALCOHOL ABUSE? ☐NO ☐YES
DO YOU HAVE A HISTORY OF DRUG USE? ☐NO ☐YES
EMPLOYMENT: ☐STUDENT ☐PART-TIME ☐FULL-TIME ☐HOMEMAKER ☐DISABILITY ☐RETIRED

I hereby give my permission to Martin C. Harris, DPM & Associates to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition and authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with the treating physicians. Furthermore, I assign all payment of medical benefits provided by my insurance company policy for medical/surgical care to Martin C. Harris & Associates.

SIGNATURE:_____DATE:_____
(Patient or legal guardian)