FAMILY FOOT & ANKLE SPECIALISTS

DR. STEVEN P. BRANCHEAU, DR. DAVID D. MINCHEY and ASSOCIATES

PATIENT INFORMATION

NAME ______________________________SOC. SEC # ______________

ADDRESS ____

BIRTH DATE ______________MARITAL STATUS ____________ GENDER ________

PHONE ____________ ALT. PHONE __________WORK PHONE ______________

EMAIL ____________________ REFERRED BY ____________________

EMERGENCY CONTACT/RELATIONSHIP ____________________PHONE __________

INSURANCE

PRIMARY INSURANCE __________________GUARANTOR ____________________

SECONDARY INSURANCE ________________GUARANTOR ____________________

IF PATIENT IS A MINOR COMPLETE THE SECTION BELOW

FATHER'S NAME ________________BIRTH DATE __________SS# __________

PHONE ____________ALT PHONE __________MARITAL STATUS ____________

ADDRESS ____

MOTHER'S NAME ________________ BIRTH DATE __________SS# __________

PHONE ____________ALT PHONE __________MARITAL STATUS ____________

ADDRESS ____

LEGAL GUARDIAN ____

SOCIAL HISTORY

LIVE WITH: ______________CAFFEINE: ________ALCOHOL ________DIET ______

EMPLOYMENT STATUS: FULL-TIME PART-TIME UNEMPLOYED RETIRED OTHER: ____________

EMPLOYER: ______________________TITLE:______________________

PAST EMPLOYERS: ____

TOBACCO USE: NON-SMOKER SMOKES ________Pack(s) a day. SMOKELESS TOBACCO ________

FORMER SMOKER: QUIT ____YEARS AGO SMOKED ____YEARS

NAME ______________________________ **DOB**__________________

HISTORY: PLEASE CIRCLE ALL APPLICABLE INFORMATION

CHILDHOOD: UNREMARKABLE, Rheumatic Fever, Polio, Cerebral Palsy, Bleeding Disorders, Musculoskeletal Disorders, Diabetes

ADULT: UNREMARKABLE, High Blood Pressure, Chest Pain, Shortness of Breath, Heart Disease, Circulatory Disorders, Diabetes, Gout, Arthritis, Seizures, Lung Problems, Kidney Disorders, Liver Disease, HIV, Ulcers, Thyroid Disease, Stroke, Cancer, Epilepsy, Tuberculosis, Chemical Dependency, Ankle Swelling

FAMILY: UNKNOWN, Hypertension, Coronary Artery Disease, Diabetes, Gout, Arthritis, Asthma, Emphysema, Glaucoma, Stroke, Cancer, Epilepsy, Bleeding Disorders, Kidney Disease, Thyroid Disease, Mental Illness, Osteoporosis, Birth Defects, Tuberculosis, Alcoholism, Sickle Cell.

MEDICATION INFORMATION

WHICH PHARMACY DO YOU USE? ______________________________ **CITY** ________________

DRUG ALLERGIES: NO KNOWN ALLERGIES, Penicillin, Sulfa, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia OTHER: ______________________________

MEDICATIONS (INCLUDE DOSING IF POSSIBLE):

1.____________________ 5. ____________________ 9. ____________________

2.____________________ 6. ____________________ 10. ____________________

3.____________________ 7. ____________________ 11.____________________

4.____________________ 8. ____________________ 12. ____________________

HEALTH INFORMATION

PRIMARY DOCTOR ______________________________ LAST SEEN? ________________

CURRENT PROBLEMS ______________________________ DURATION ________________

CAUSED BY ____________________ RELIEVED BY ____________________

AGGRAVATED BY ____________________ PRIOR TREATMENT ____________________

WAS THIS AN ACCIDENT? __________ AT WORK? __________ WERE THEY NOTIFIED? __________

ARE YOU DIABETIC? __________ ARE YOU PREGNANT? __________ ARE YOU BREASTFEEDING? __________
HEIGHT________WEIGHT______SHOE SIZE______

SURGICAL HISTORY

PREVIOUS SURGERIES (INCLUDE DATES IF POSSIBLE): ______________________________

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HOSPITALIZATIONS ____

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