ACTIVE FOOT & ANKLE CARE, LLC

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Name_____Birth Date_____Age_____Weight_____Height_____

Address_____City_____State_____Zip_____

Home Phone(___)_____Cell Phone(___)_____Work Phone(___)_____
(Please indicate which is the best number to contact you by marking an *)

Gender M – F Marital Status_____ **E-Mail Address**_____ Shoe Size_____

Preferred Language _____ Preferred Phone Communication Home Work Cell
(As required under the new billing insurance guidelines)

Race _____ Ethnicity_____ Pharmacy/Address_____

Referred By (Please Circle): DrRun.com / Facebook / Google - Internet / Zoc Doc / Other_____

Physician Referral (who?): _____ **Family/Friend (who?):** _____

Occupation_____ Employer & Address _____Employment Status P/T or F/T

Student: Year_____School_____ Coach_____

Sports, Activities or Hobbies_____ Family Doctor & Town _____

Medical Insurance_____Social Security_____

Do you have or have you had any of the following: (*do not know)

	YES	NO	DNK		YES	NO	DNK		YES	NO	DNK
Foot / Leg Surgery...	☐	☐	☐	Heart Trouble.....	☐	☐	☐	Gout	☐	☐	☐
Foot / Leg Injuries...	☐	☐	☐	Diabetes.....	☐	☐	☐	Anemia.....	☐	☐	☐
Foot / Leg Cramps. .	☐	☐	☐	Epilepsy.....	☐	☐	☐	Fainting Spells..	☐	☐	☐
Foot / Leg Numbness	☐	☐	☐	Liver Disease.....	☐	☐	☐	Bleeder.....	☐	☐	☐
Knee Pain.....	☐	☐	☐	Kidney Disease.....	☐	☐	☐	Blood Disease...	☐	☐	☐
Unequal Leg Length.	☐	☐	☐	Rheumatic Fever.....	☐	☐	☐	Circulation Issues	☐	☐	☐
Weak Ankles.....	☐	☐	☐	High Blood Pressure..	☐	☐	☐	Hardening Arteries	☐	☐	☐
Bunions.....	☐	☐	☐	Polio.....	☐	☐	☐	Varicose Veins...	☐	☐	☐
Foot Skin Problems .	☐	☐	☐	Bursitis.....	☐	☐	☐	Arthritis.....	☐	☐	☐
Toe Nail Problems...	☐	☐	☐	Stomach Ulcers.....	☐	☐	☐	Cancer.....	☐	☐	☐
Low Back Pain.....	☐	☐	☐	Asthma.....	☐	☐	☐	Prone to Infection	☐	☐	☐

Are you allergic to or sensitive to

	YES	NO	DNK
Novocaine.....	☐	☐	☐
Penicillin.....	☐	☐	☐
Adhesive Tape.....	☐	☐	☐
Materials.....	☐	☐	☐
Drugs.....	☐	☐	☐
Foods.....	☐	☐	☐
Stainless Steel.....	☐	☐	☐
Latex.....	☐	☐	☐
Other (if so describe)	☐	☐	☐
_____			
_____			

List any medical conditions you have._____

Have you had any serious illnesses or operations?_____

Have you had any injuries or operations on your feet or legs?_____

Have your or any family members been treated for diabetes?_____ If yes, who?_____

List any allergies to medications._____

Present medications being taken:_____

My chief complaint is:_____

I hereby give permission to Richard T. Braver D.P.M, and/or Associates for the examination and rendering care for my foot/ankle problem and / or related condition.

Date_____ Patient Signature (if minor, parents)_____