Ankle & Foot Center

Howard J. Bonenberger, DPM, PLLC

Name: ______________________________ Date: ____________________

Street: ______________________________ City____________ State_____ Zip________

Home tel# (____)______________Work #: (____)______________ Cell #:(____)______________

Birthdate: ________________ Age: _____ Gender: _____ Height: _____ Weight: _____

SS #________________ Marital status: S M D W Shoe size: ____________

Employer: ____________________ Occupation: ______________________

Parent/Guardian): ____________________ Emergency contact: ____________________
(If pt is a minor) Tel #: ____________________

Family Dr: ____________________ Pharmacy & location: ____________________

Do you have any ALLERGIES? **NO** **YES –please list below**

____

____

Are you currently taking any MEDICATIONS? **NO** **YES –please list below**

____

____

____

Past Medical History/Systems Review:

Please **circle** no or yes if you have had problems with the following: **briefly** explain if necessary

Anemia	no yes ________	Hypertension	no yes ________
Arthritis	no yes ________	Kidney disease	no yes ________
Asthma	no yes ________	Liver disease	no yes ________
Bleeding tendencies	no yes ________	Lung conditions	no yes ________
Bones/joints	no yes ________	Nervous system	no yes ________
Cardiovascular/heart	no yes ________	Phlebitis	no yes ________
Cancer	no yes ________	Psychiatric difficulties	no yes ________
Circulation	no yes ________	Seizures	no yes ________
Depression	no yes ________	Stomach/intestinal	no yes ________
Diabetes Insulin dependent	no yes ________ no yes	Stroke	no yes ________
		Skin related problems	no yes ________
Fainting	no yes ________	TB	no yes ________
Gout	no yes ________	Thyroid disease	no yes ________
Hepatitis	no yes ________		

Cont'd on reverse side – please complete

Please list any other medical conditions not covered above that you have had or have now:

____

Please list any prior surgeries you have had: ____

____

Do you require antibiotics for dental work? (If yes, please explain) ______________________________

Family History: Please list immediate family members who have/had the following:

Arthritis: ______________________________

Birth defects: ______________________________

Bleeding disorders: ______________________________

Cancer: ______________________________

Diabetes: ______________________________

Foot problems: ______________________________

Heart conditions: ______________________________

Hypertension: ______________________________

Stroke: ______________________________

Social History:

Alcohol use:
- No
- Social
- Mild
- Moderate
- Heavy
- Recovering

Illegal drug use:
- No
- Yes

Tobacco use:
- Yes, currently

______ packs per day
for ______ years

- Prior history
- Never

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- Are you currently pregnant? Yes No
- What is your chief complaint today? ____
- How long has this been bothering you? _________ days / weeks / months / years
- List any previous treatment for this

  ____
- Is there anything else you would like the doctor to know?

  ____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have Read (or had the opportunity to read if I so chose) and understood the Notice.

____ ______________________________

Patient name (please print) Date

____

Name of Parent or authorized representative (if applicable)

____

Signature