

**UNIVERSITY FOOT SPECIALISTS**

Kenneth H. Zygmunt, D.P.M.    David J. Lawrence, D.P.M.    William M. Noorlag, D.P.M.

Patient \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone(Home) \_\_\_\_\_ Phone(Work) \_\_\_\_\_ Phone(Cell) \_\_\_\_\_

Marital Status \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Sex: M F (circle) Student: YES NO (circle)

Social Security # \_\_\_\_\_

If patient is a minor, who is responsible for payment of services? \_\_\_\_\_

Reason for seeing the doctor today \_\_\_\_\_

When did the problem start? \_\_\_\_\_

Your family physician's name \_\_\_\_\_

Date you last saw your doctor \_\_\_\_\_

Whom may we thank for referring you to this office?

Physician(name) \_\_\_\_\_

Insurance \_\_\_\_\_

Family or Friend(name) \_\_\_\_\_

Yellow pages \_\_\_\_\_

**INSURANCE INFORMATION**

Relationship of PATIENT to Insured:    SELF    SPOUSE    CHILD    OTHER (please circle)

Name of INSURANCE COMPANY \_\_\_\_\_

Insured's name \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Insured's birth date \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary insurance \_\_\_\_\_ Insured's Name \_\_\_\_\_

Employer \_\_\_\_\_ Insured's Birth date \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Group # \_\_\_\_\_

Relationship of PATIENT to Insured:    SELF    SPOUSE    CHILD    OTHER (please circle)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE FILING AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES PERFORMED. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THE BILL.

Signed \_\_\_\_\_ Date \_\_\_\_\_

UNIVERSITY FOOT SPECIALISTS

Kenneth H. Zygmunt, DPM

William M. Noorlag, DPM

David J. Lawrence DPM

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Do you have or have you had any of the following diseases or problems? Please check

- Rheumatic fever or rheumatic heart disease
- Congenital heart problems
- Cardiovascular disease (stroke, CVA, heart trouble, heart attack, high blood pressure, coronary occlusion, arteriosclerosis)
- Have chest pain upon exertion
- Short of breath after a mild exercise
- Ankles swell
- Short of breath when you lie down or do you require extra pillows under your head and shoulders when you sleep
- Have you ever been told that you have a heart murmur
- Allergies
- Sinus trouble, asthma or hay fever
- Hives or a skin rash
- Fainting spells or seizures
- Diabetes
- Hepatitis, jaundice or liver disease
- Arthritis
- Inflammatory rheumatism
- Kidney trouble
- Stomach ulcers
  - Can you tolerate aspirin?
- Tuberculosis
- Persistent cough or cough up blood
- Low blood pressure
- Poor circulation
- Leg pain/cramps when walking
- Pain in your feet when they are elevated
- Wounds/ulcers on your feet which were slow to heal
- Blood clots/deep vein thrombosis
- Taken blood thinners
- Abnormal bleeding associated with extractions, surgery trauma
- Bruise easily
- Have required a blood transfusion
- Blood disorder such as anemia, sickle cell anemia or trait

Are you taking any of the following? Please check

- Antibiotics or sulfa drugs
- Anticoagulants (blood thinners)
- Medicine for high blood pressure (water pills)
- Cortisone (steroids)
- Tranquilizers
- Antihistamines
- Aspirin
- Insulin, Tolbutamide (Orinase or similar drug)
- Digitalis or drugs for heart trouble
- Nitroglycerin

Are you taking any drug or medicine? If so, please list below

_____	_____
_____	_____
_____	_____

Are you allergic to or have you reacted adversely to, or been told not to take:

- Local anesthesia
- Penicillin or other antibiotic
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin
- Iodine
- Codeine or other narcotics

Are you pregnant  Yes  No

Do you smoke  Yes  No

Are you, or have you been in any of the following groups:

- IV drug user
- Herpes Simplex
- Blood transfusion 1978 to March 1985
- Homosexual
- Hemophiliac
- Hemodialysis
- Hepatitis
- Been intimate partner of someone in one of these groups

Surgical History

_____	_____
_____	_____
_____	_____