

Dr. Terry L. Spilken Dr. Kelly Oliveros

DOCTORS OF PODIATRIC MEDICINE

DATE _____

PATIENT INFORMATION

To help us fully evaluate your problem, please print clearly the following information:

NAME _____ SEX _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME (____) _____ - _____ CELL (____) _____ - _____ BIRTHDATE ____/____/____

____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ WORK PHONE (____) _____ - _____

SOC SEC # ____/____/____ REFERRED BY _____

FAMILY PHYSICIAN _____ LAST VISIT _____

ADDRESS _____ PHONE (____) _____ - _____

INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____ BIRTHDATE ____/____/____

WHAT IS YOUR FOOT COMPLAINT? _____

_____ FOR HOW LONG? _____

HAVE YOU RECEIVED PREVIOUS CARE ____ YES ____ NO LAST VISIT _____

GENERAL HEALTH ____ GOOD ____ FAIR ____ POOR ANY OPERATIONS? _____

MEDICINES YOU TAKE _____

IF YOU HAVE ANY OF THE FOLLOWING, PLEASE CHECK:

- | | |
|-------------------------------------|------------------------------------|
| ____ ANEMIA | ____ HEART TROUBLE |
| ____ ARTHRITIS OR BURSITIS | ____ HIGH BLOOD PRESSURE |
| ____ ASTHMA | ____ HIV POSITIVE |
| ____ BLOOD DISEASE | ____ KIDNEY TROUBLE |
| ____ BROKEN BONES IN FEET OR LEGS | ____ LIVER TROUBLE |
| ____ CANCER | ____ RAYNAUD'S DISEASE |
| ____ CIRCULATION DISEASE | ____ STOMACH ULCER |
| ____ DIABETES | ____ SUBJECT TO PROLONGED BLEEDING |
| ____ DIFFICULTY IN HEALING WHEN CUT | ____ TUBERCULOSIS |
| ____ EPILEPSY | ____ VARICOSE VEINS |
| ____ HEARING PROBLEMS | ____ VENEREAL DISEASE |
| ____ OTHERS _____ | |

ARE YOU ALLERGIC OR SENSITIVE TO:

- | | | |
|----------------------|-----------------|--------------|
| ____ ADHESIVE TAPE | ____ CORTISONE | ____ SULPHUR |
| ____ ANY ANTIBIOTICS | ____ IODINE | |
| ____ ASPIRIN | ____ NOVOCAINE | |
| ____ CODEINE | ____ PENICILLIN | ____ NONE |
| ____ OTHERS _____ | | |

I HEREBY GIVE PERMISSION TO DRs. SPILKEN OR OLIVEROS TO EXAMINE ME AND TO PERFORM SUCH MEDICAL, SURGICAL OR ORTHOPEDIC PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT CONDITION.

DATE _____ SIGNATURE _____