Jeffrey L. Bober, DPM, PA
Foot Care for the Whole Family
Registration and History Form

Todays Date:_____

Name_____

Address_____

_____
City State Zip

Sex:___M___F Age:__Birthdate_____SSN:_____

___Single___Married___Widowed___Divorced___Seperated

Home Phone_____Cell Phone_____

Email Address_____Can we Email Reminders? Yes/ No

Employer_____Work Phone_____

Employers Address_____

_____
City State Zip

_____
Spouses Name

In Case of Emergency Please Contact

Name_____

Relationship_____Phone_____

Primary Care Doctor/ Family Doctor_____

Address and Phone of Doctor_____

Pharmacy Name _____

Pharmacy Phone and Location_____

Name*:*_____**Date**:_____

Past Medical History

What medical problems have you had, or are you being treated for

Arthritis Diabetes Cancer Heart Disease Gout

Anemia Hepatitis Stroke High Blood Pressure Kidney Disease

Bleeding Disorder HIV/AIDS Liver Disorder High Cholesterol PVD

Thyroid Disorder Respiratory Stomach/Intestinal Neurological Seizures

Other:_____

Medications: Please list **ALL** medications you are taking including aspirin, vitamins, and supplements.

Allergies : Please list any allergies to medications_____

No Known Drug Alleriges

Past Surgical History: Please list any surgeries you have had

_____

_____

Have you been in the hospital in the last year? Yes/ no if so for what condition?_____

Family History

Please list whether anyone in your immediate family has any of the following: arthritis, diabetes, heart disease, cancer, bleeding disorder, high blood pressure, or any other serious medical condition

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Social History

Are you a smoker? Yes or No How many packs per day?____Were you ever a smoker? Yes/No

Do you drink alcohol? Yes/No How often?_____Do you use recreational drugs? Yes/No Marijauna/Narcotics

Consent for Treatment- I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr Bober, to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my foot and or ankle.

Signature of Patient or Guardian **Date**:

Name_____**Date**_____

Height_____**Weight**_____**Shoe Size**_____

Please describe the reason for your visit to the Dr today, and which foot, feet or toes are affected

How long has this problem been occurring?

_____spontaneous/ injury_____days_____weeks_____months_____years

If from an injury, how?

_____

Is there pain associated with your foot problem and what type? Dull, ache, burning, throbbing, tingling, and or shooting? _____

Have you been seen by a podiatrist or other health practitioner for this problem before?

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____

Doctor Referral (who?)_____ Insurance Company_____

Facebook_____ Other_____