Family Foot and Ankle Specialists
Dr. Brant Burnham, DPM

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New patient information

First name_____ Middle Initial____ Last Name_____

Date of Birth _____ Gender __M __F Social Security #_____-- _____-- _____

Address_____ City _____ State____ Zip code _____

Home phone _____

Cell Phone _____ other phone _____

Email address _____

Marital status: __ single ____Married ___Divorced ____Widowed ___ Other

Employment information

Employer _____ Job Title _____

Work Address _____ City _____ State_____ Zip Code_____

Work Phone number_____ Employment status: ___Full time __ Part time

___Retired ___self-employed ___unemployed Other_____

Emergency Contact

Name_____ Relationship to patient_____ Phone Number_____

Insurance information

Primary policy:

Insurance Carrier_____

ID/policy number_____

Name of policy holder_____

Date of Birth of Policy Holder _____

Relationship to patient_____

Secondary Policy:

Insurance Carrier_____

ID/policy number_____

Name of policy holder_____

Date of Birth of Policy Holder_____

Relationship to patient_____

Primary care Physician (PCP): _____ **Date of last PCP visit:** _____

Pharmacy of choice: _____ **Location:** _____

Reason for your visit today

Why are you seeing the doctor today?

_____

_____

Is there pain associated with this condition? ____Yes ____No

Type of pain ___ sharp ___dull ___aching ___throbbing ___ burning ___tingling ___numbness

___other, please describe _____

Where is the pain located, where is the worst spot?

_____

_____

How long has the problem been present, when did it start?

_____

Was the onset of the problem ___ sudden or ___ gradual?

What causes or aggravates the problem?

_____

What have you done to relieve the pain/treatments?

_____

Was the treatment helpful? ____yes __No ___A little

Is there any other information you would like us to know about the problem?

_____

_____

_____

_____

_____

Who may we thank for your referral today?

_____

How did you hear about our practice?

_____

Shoe size_____ Height_____ Weight_____

Past medical history

Please check any condition that currently apply OR that you have experienced in the past:

Constitutional/General
__Cancer Type_____
__Elevated Temperature
__Night Sweat

Cardiovascular
__Angina
__Blood Clots/ DVT
__Easy Bruising/ Bleeding
__Heart Attach
__Hypertension
__Irregular Heartbeat
__Poor Circulation
__Rheumatic Fever
__Valve Problems
__ Stroke

Respiratory
__Asthma
__Chronic Cough
__COPD
__Emphysema
__Shortness of Breath
__Sleep Apnea/ CPAP

Infectious Disease
__HIV/ AIDS
__STDs
__Tuberculosis/ TB

Gastrointestinal
__Acid Reflux/ GERD
__Gall Bladder
__Hiatal Hernia
__IBS
__Stomach/ Bowel Problems
__Ulcers

Genito- Urinary
__Bladder or Kidney Stone
__Infection
__Kidney Failure
__Dialysis
__Prostate Disease

Endocrine
__Heat or cold intolerance
__Diabetes
__Hyperthyroid
__Hypothyroid

Hematologic Disease
__Anemia, Type _____
__Sickle Cell

Liver
__Cirrhosis
__Hepatitis
__Jaundice

Hearing/ Vision
__Double/ Blurred vision
__Glaucoma
__ Macular Degeneration
__ Vision Changes
__ Contacts/ Glasses
__ Hearing Deficit/loss
__Hearing Aid

Nervous System
__Anxiety
__Depression
__Convulsions/ Epilepsy
__Fainting
__Memory loss
__Migraines
__Neuropathy
__Muscle Weakness
__Muscular Dystrophy
__Multiple Sclerosis
__ Parkinson's Disease

Other
_____
_____
_____
_____

Surgical History:

Please list any surgeries and year

Medications

Please include prescriptions, over the counter, vitamins and supplements.

(For your convenience, you can also submit a **current medication list via fax or email).**

Medication	Dosage	Frequency

Allergies

Please indicate all allergies to medications:

Medication Reaction

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other allergies: __Adhesive __Band-Aids/ Tape __Latex __ Iodine __ Foods _____

Do you have any complication due to Anesthesia? __Yes __ No Describe_____

Social History

1-Do you currently smoke or chew tobacco? __Yes __No If yes, how many packs/cans per day? _____

If NO, have you in the past? ___Yes __No For how many years _____

2-Do you drink alcohol? __Yes __No How many glasses/drinks per day? _____

3-Do you drink caffeine? __Yes __No How many cups/ drinks per day? **_____**

4-Do you use any illicit drugs (I, e. Marijuana, cocaine, heroin, etc.)? __Yes __No If YES which drugs?

_____ if NO, have you in the past? __Yes __No

Family Health History:

Mother	
Father	
Siblings	
Children	
Maternal Grandparents	
Paternal grandparents	

_____

Signature / Date