Foot Care Specialists, PLLC
LaWanda Bailey-Rayner, DPM

Personal Information

Name:_____
Address: _____
Phone # : _____ Alt Phone # : _____
Date of Birth: _____/_____/_____ Social Security # :_____/_____/_____
Age: _____ Sex: **M / F** Height _____ Weight _____ Shoe Size: _____
Marital Status: _____ Email address: _____
Patient's Employer: _____ Phone# : _____
Occupation: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: ____/_____/_____

Emergency Contact: _____ Relationship to Patient:_____
Address: _____ Phone #: _____

Primary Care Physician: _____

Pharmacy Name: _____ Pharmacy # _____

Primary Problem: _____

How long have you had this problem? : _____

Have you ever been treated for this problem, **IF** yes, explain? :_____
_____
Could you be pregnant? ( ) Yes ( ) No
Are you a smoker?_____ Do you have a history of smoking?_____
How many packs a day?_____

Do you consume Alcoholic Beverages? _____
Drinks per day/or per week? _____

Do you have artificial joints? _____ IF so, which joints?
_____

Do you have a Heart Valve Implant? Please explain:

Have you had any or any other surgeries? Yes or No If so please list below:
_____
_____
_____
_____

MEDICAL INFORMATION

Are you allergic to any medications? **IF** yes please list medication and reaction:

_____

_____

Do you have problems with local anesthetics such as Novocaine or Lidocaine? **IF** yes please explain:

_____

_____

Are you allergic to **tape** or **latex**? _____ Do you take Aspirin? _____
Do you take **Coumadin** or a **Blood Thinner**? _____

List your current medications: _____

_____

_____

_____

Please circle any problems you have or have had with below:

Heart	Kidneys	Lupus
Arthritis	Stroke	Gout
Burns	Circulation	Anemia
Skin	Nerves	Liver
Angina	Hypertension	Asthma
Cancer	Hypercholesterolemia	Intestines
HIV/AIDS	Thyroid	Rheumatic Fever
Diabetes	Healing	Tuberculosis
Stomach Ulcers	Eyes	Genetic Disease
Frequent Infections		

I certify to the best of my knowledge that all of the information above is correct.

_____ _____

Signature Date

FAMILY HISTORY

Are your parents still living? Yes No
If NO, what was the cause of death? _____
Please check the following health condition associated with mom,dad,grandparents**.**

		Relationship
	Alzheimer's Disease	
	Aneurysm (Specify)_____	
	Arthritis	
	Asthma	
	Cancer (Specify)_____	
	Congestive Heart Failure	
	COPD	
	Dementia	
	Diabetes	
	DVT (Blood Clot)	
	Emphysema	
	Foot Deformities (Specify)	
	GERD (Heart Burn)	
	Heart Disease	
	Hepatitis	
	Hypercholesterolemia	
	Hypertension (High Blood Pressure)	
	Hyperthyroidism	
	Hypothyroidism	
	Kidney Disease	
	Lung Disease	
	Lupus	
	Migraines	
	Myocardial Infarction(MI-Heart Attack)	
	Parkinson's Disease	
	Pneumonia	
	PVD (Peripheral Vascular Disease)	
	Renal Failure	
	Stomach Ulcer	
	Stroke	
	Tumor	
	Toenail Problems	
	Tuberculosis	
	Unknown	
	Unknown of Family History	
	Other Disease	