Advanced Foot Care Center — Morse K. Upshaw, DPM, Inc.

Thank you for visiting our office. We would like to give you the highest quality of care possible. Please fill out the information below to help us.

Personal Information

Last Name:	MI:	First Name:	Sex:	Social Sec. #:	Birth Date:	Age:

Address:	City:	State:	Zip:	Spouse Name:

Phone Number:	Emergency Contact:	Pharmacy Name. #:	Please Circle:
Home: (____) ____-_____	_____	_____	Married Single
Work: (____) ____-_____	Phone: (___) ___-_____	Phone: (___) ____-_____	Widowed Divorced
Cell: (____) ____-_____			

Occupation:	Employer:	Work Address:

Primary Insurance Co.	Subscriber's Name:	Policy #:	Group #:

Secondary Insurance Co.	Subscriber's Name:	Policy #:	Group #:

Family Doctor:	Address:	Phone #: (____) ____-_____	Last Visit:

How were you Referred?	E-mail Address:

General Medical History (So that our records are accurate, please fill in all information.)

What is your current Foot/Ankle Problem?	Height:	Weight:	Shoe Size:

Are you **ALLERGIC** to any of the following? (please circle all that apply)

___NONE OF THESE	Codeine	Tape
Novocaine	Penicillin	Other:
Aspirin	Sulfa	
Demerol	Iodine/Betadine	

Have you had treatment for:

Foot Surgery	Numbness/Tingling
Broken Bones	Ulcers
Cramps, leg or foot	Fungal Nails
Heel Pain	Other:

Do you have or have been treated for: (Please circle all that apply).

___NONE OF THESE	Chest Pain	Arthritis	Seizures
Weight loss/gain	Lung Disease	Hepatitis	Bleeding Tendencies
Weakness/Fatigue	Shortness of Breath	HIV/AIDS	Rheumatic Fever
High Blood Pressure	Nausea	Diabetes	Heart Attack/Surgery
Vision Problems	Stomach Ulcers	Kidney	Stroke
Heart Disease	Abdominal Pain	Cancer	Other:

Do you have vascular grafts? _____
Do you have heart valve replacements? _____
Do you have joint replacements? _____
Are you under active chemotherapy? _____
Have you had any other serious illnesses? _____
Have you had any surgery or complications to surgery?
Surgery for:_____ Date:_____
_____ _____
_____ _____

Is there a **Family History** of:

Arthritis:_____	High Blood Pressure
Blood Clots: ____	Keloids: _____
Cancer: _____	Stroke: _____
Diabetes: _____	Other: _____
Heart Attack:	

Social History: Do you smoke now? _____ Did you? _____
How many years? _____ Packs/day_____
Alcoholic Beverages? None Rarely Daily How Much?

Recreational Drugs? None Rarely Daily How Much?
How active are you: Not much / Moderate / Athletic

Current Medications Taking: **Dose:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Patient Signature: _____ **Date:** _____
Signature of Patient, Parent or Guardian)