



# WILMETTE FOOT & ANKLE CLINIC

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## PATIENT INFORMATION FORM

# 1

### PERTINENT INFORMATION

PLEASE PRINT

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
last first mid. init.

SOCIAL SECURITY NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX M F  
month day year

HOME ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

\*E-MAIL \_\_\_\_\_

\* (CONSENT FOR USE) \_\_\_\_\_

MARITAL STATUS  SINGLE  MARRIED  
 PARTNERED  SEPARATED  
 DIVORCED  WIDOWED

ARE YOU A STUDENT / MINOR? (PLEASE REFER TO SECT. 2\*.)

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE

POWER OF ATTORNEY?  YES  NO

IF YES, NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

WHO REFERRED YOU TO US? \_\_\_\_\_

PHARMACY \_\_\_\_\_

LOCATION \_\_\_\_\_

PHONE \_\_\_\_\_

# 2

### ACCT / INSURANCE INFORMATION

NAME OF PERSON RESPONS. FOR ACCT / RELATIONSHIP (GUARANTOR) \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
month day year

\*IF CHILD BEING TREATED, PERSON RESPONS. FOR ACCT/ RELATIONSHIP

BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
month day year

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY\*  
\*(IF CARD IS NOT PRESENT) \_\_\_\_\_

NAME OF SECONDARY INSURANCE,  
IF APPLICABLE \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SUBSCRIBER'S BIRTHDATE \_\_\_\_\_  
month day year

SUBSCRIBER'S SOC. SECUR. NO. \_\_\_\_\_

# 3

### PODIATRIC HISTORY

WHAT IS YOUR CHIEF COMPLAINT FOR WANTING TREATMENT?  
(INCLUDE FOOT, ANKLE, KNEE, THIGH AND HIP COMPLAINTS).  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU BEEN TO A PODIATRIST BEFORE? YES NO

DOCTOR'S NAME \_\_\_\_\_

LAST VISIT \_\_\_\_\_

PLEASE INDICATE WHICH FOOT PROBLEMS YOU NOW HAVE OR  
HAVE HAD IN THE PAST.

- |  |   |
|--|---|
| <input type="checkbox"/> ANKLE PAIN                            | <input type="checkbox"/> FOOT OR LEGS CRAMPS        |
| <input type="checkbox"/> ATHLETE'S FOOT                        | <input type="checkbox"/> HEEL PAIN                  |
| <input type="checkbox"/> CORNS & CALLUSES                      | <input type="checkbox"/> INGROWN TOENAILS           |
| <input type="checkbox"/> CRAMPS OR NUMBNESS<br>IN FEET OR LEGS | <input type="checkbox"/> PLANTAR WARTS              |
| <input type="checkbox"/> FLAT FEET                             | <input type="checkbox"/> SWELLING IN ANKLES OR FEET |
|  | <input type="checkbox"/> TIRED FEET                 |



# 4 MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS)

NAME

DOSE

HOW OFTEN IS IT TAKEN?

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# 5 PLEASE LIST PRIOR SURGERIES

TYPE OF SURGERY

DATE

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

# 6 PRIOR HOSPITALIZATIONS

LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN SURGERY)

DATE

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

# 7 ALLERGIES

- |  |                                  |  |                                   |
|--|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> ADHESIVE TAPE         | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LOCAL ANESTHETICS | <input type="checkbox"/> SEAFOODS |
| <input type="checkbox"/> ANTICOAGULANT THERAPY | <input type="checkbox"/> DEMEROL | <input type="checkbox"/> NOVOCAINE         | <input type="checkbox"/> SULFA    |
| <input type="checkbox"/> ASPIRIN               | <input type="checkbox"/> IODINE  | <input type="checkbox"/> PENICILLIN        | OTHER _____                       |

# 8 SOCIAL HISTORY

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HOW MUCH ARE YOU ON YOUR FEET AT WORK?  10%  25%  50%  100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE?  CHILDREN - AGE(S) \_\_\_\_\_  PET(S) - WHAT KIND? \_\_\_\_\_

ELDERLY OR DISABLED FAMILY MEMBER  OTHER \_\_\_\_\_

EXERCISE  NEVER  RARE  OCCASIONAL  WEEKLY  SEVERAL TIMES A WEEK  DAILY

TYPES OF EXERCISE \_\_\_\_\_

USE OF ALCOHOL  NEVER  NO LONGER USE  HISTORY OF ALCOHOL ABUSE

CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ SMOKE \_\_\_\_\_ PACKS/DAY FOR \_\_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_

CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY



# 9 MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

|                              |     |                              |     |                           |     |
|------------------------------|-----|------------------------------|-----|---------------------------|-----|
| ACID REFLUX _____            | Y N | FIBROMYALGIA _____           | Y N | OPEN SORES _____          | Y N |
| ANEMIA _____                 | Y N | GOUT _____                   | Y N | PNEUMONIA _____           | Y N |
| ARTHRITIS _____              | Y N | HEART ATTACK _____           | Y N | POLIO _____               | Y N |
| ASTHMA _____                 | Y N | HEART ATTACK / FAILURE _____ | Y N | PSYCHIATRIC CARE _____    | Y N |
| BACK TROUBLE _____           | Y N | HEPATITIS _____              | Y N | RHEUMATIC FEVER _____     | Y N |
| BLADDER INFECTIONS _____     | Y N | HIV+ / AIDS _____            | Y N | SICKLE CELL DISEASE _____ | Y N |
| ABNORMAL BLEEDING _____      | Y N | HIGH BLOOD PRESSURE _____    | Y N | SKIN DISORDER _____       | Y N |
| BLOOD CLOTS _____            | Y N | KIDNEY DISEASE _____         | Y N | SLEEP APNEA _____         | Y N |
| BLOOD TRANSFUSION _____      | Y N | LIVER DISEASE _____          | Y N | STOMACH ULCERS _____      | Y N |
| BRONCHITIS / EMPHYSEMA _____ | Y N | LOW BLOOD PRESSURE _____     | Y N | STROKE _____              | Y N |
| CANCER _____                 | Y N | MIGRAINE HEADACHES _____     | Y N | THYROID DISEASE _____     | Y N |
| DIABETES _____               | Y N | MITRAL VALVE PROLAPSE _____  | Y N | TUBERCULOSIS _____        | Y N |
|                              |     | NEUROPATHY _____             | Y N | VASCULAR CONCERNS _____   | Y N |

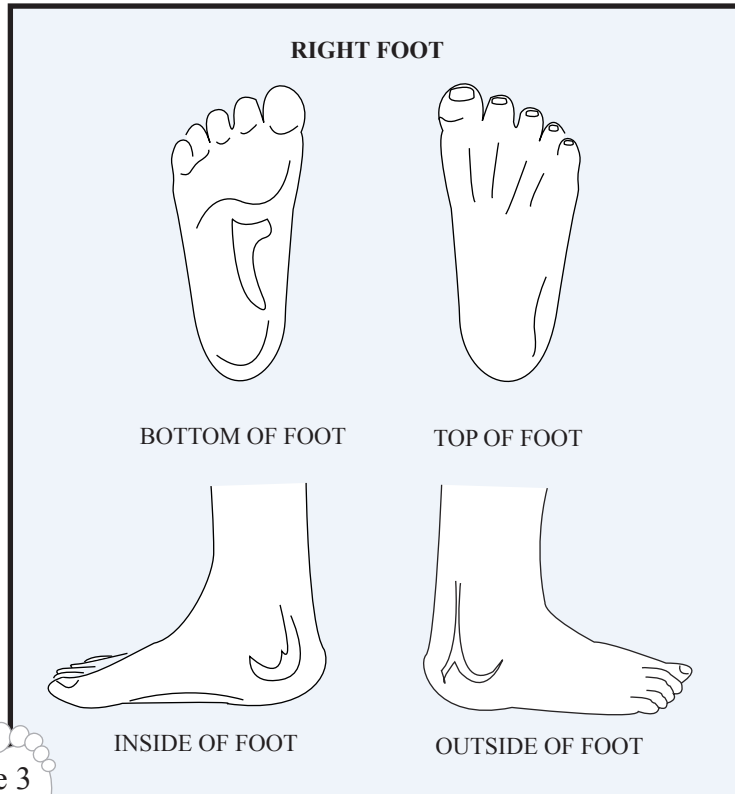
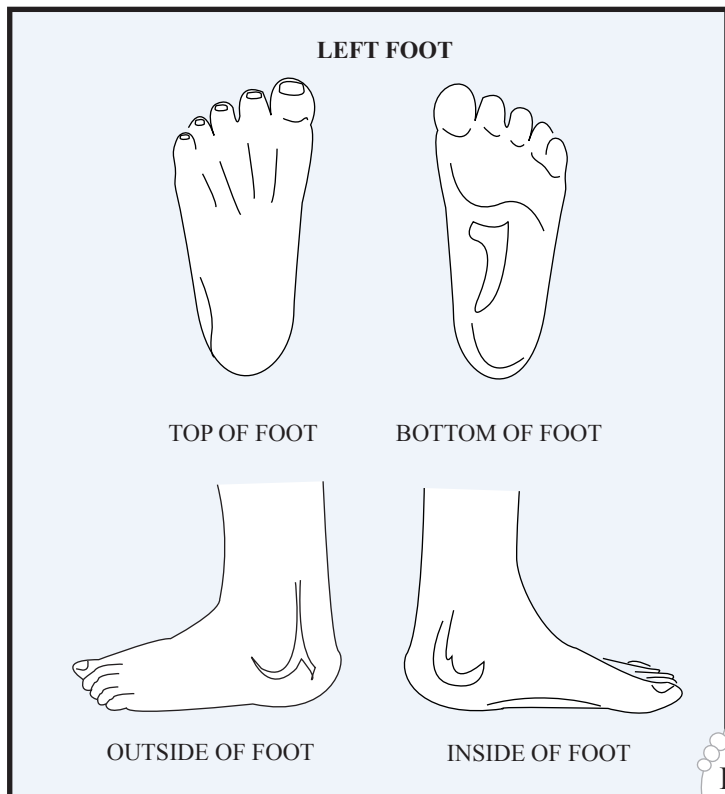
OTHER CONDITIONS \_\_\_\_\_

# 10 FAMILY HISTORY

- DO YOU HAVE A FAMILY HISTORY OF:
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> DIABETES      | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RHEUMATOID ARTHRITIS    |
| <input type="checkbox"/> CANCER        | <input type="checkbox"/> STROKE              | <input type="checkbox"/> CORONARY ARTERY DISEASE |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> THYROID DISEASE     | <input type="checkbox"/> OTHER                   |

# 11 CURRENT PROBLEM

WHERE IS THE PAIN / PROBLEM LOCATED?  
PLEASE MARK ON THE PICTURES BELOW.





# 11

## CURRENT PROBLEM, *continued*

WHEN DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?  NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER

HOW WOULD YOU RATE YOUR PAIN ON A SCALE OF 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT  STAYED THE SAME  BECAME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES  
 RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES DESCRIBE \_\_\_\_\_

IF YES, WAS IT A WORK-RELATED INJURY? YES  NO

## TREATMENT CONSENT

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

I HEREBY GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

**FOR OFFICE STAFF:** IF PATIENT DOESN'T HAVE OR DOES NOT WISH TO USE THEIR INSURANCE, MAKE A COPY OF THEIR DRIVER'S LICENSE OR STATE I.D., AND ALSO WRITE THE NUMBER IN THE SPACE BELOW.