

FAMILY FOOT & ANKLE PHYSICIANS
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□WC

Welcome. Please print your responses to the following questions. This is part of your medical record.

Full Name _____ Date of Birth ____/____/_____
Address _____ Gender M F Age _____
City / State / Zip _____ Social Security # _____ - _____ - _____
Phone Numbers Home (____) _____ - _____ Cell (____) _____ - _____
Marital Status: Single Married Divorced Employer Name and Address: _____
(Please circle one) Widow / Widower _____
Emergency Contact Occupation _____
(Other than someone living with you) Work Phone (____) _____ - _____
Name _____, Relationship _____
Phone (____) _____ - _____

Insurance Name of Medical and/or Surgical insurance companies under which you are covered:
1. _____
THROUGH SELF ____ SPOUSE ____ WORK ____ PARENT ____
Insured's Date of Birth: ____/____/____ (If other than THROUGH SELF)
2. _____
THROUGH SELF ____ SPOUSE ____ WORK ____ PARENT ____
Insured's Date of Birth: ____/____/____ (If other than THROUGH SELF)

How did you find out about our office? _____

MEDICAL INFORMATION

Primary Care Provider's Name and Address: _____

Date of last visit with your PCP: ____/____/____

Are you currently under your doctor's care? Yes No

If so, for what reason: _____

What is your height? _____ weight? _____ shoe size? _____

Have you had previous treatment by a podiatrist? Yes No When? ____/____/____

For what reason? _____

What is the reason for your visit today? _____

Do you have or have you had any of the following? Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach/Intestinal Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing/Lung Problems | <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Rheumatic/Scarlet | |
| <input type="checkbox"/> Glaucoma | Fever | |
| <input type="checkbox"/> Heart Trouble | | |

Does anyone in your immediate family have any of the above conditions? (Please mention) _____

Please list the medications you are taking including aspirin and birth control: _____

ALLERGIES Are you allergic to ...

- | | | |
|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Novocain | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | |

Do you smoke? _____ How many packs per day? _____ Do you use alcohol? _____

How much do you drink per week? _____

Do you use street drugs? _____ Please name: _____

Have you been in contact with the AIDS virus? _____

Please list and date any surgeries you've had since childhood: _____

Is there anything else we should know about your general health? _____

I certify that the above information is true and correct to the best of my knowledge. I hereby give Dr. Stancil and Dr. Pitzer permission to administer and perform such procedures as may be deemed necessary to diagnose and/or treat my feet. Also, I understand that photographs may be taken of my feet and are part of my medical record.

Signature (Signature of Parent or Guardian if under 18 years of age)

Date