THE BUNION SPECIALIST

Dr. Richard M. Cowin, DPM

Welcome

PATIENT INFORMATION

Date_____ Patient Name_____

Address_____

City_____ State_____ Zip_____

Email_____

Sex [ ]M [ ]F Age_____ Birthdate: _____/_____/_____Weight:_____ Shoe Size:____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Other Phone (_____) _____

Best time and place to reach you_____

IN CASE OF EMERGENCY CONTACT

Name_____Relationship_____

Home Phone (____)_____ Other Phone (____) _____

FOOT HISTORY

What type(s) of foot problem(s) are you having? _____

_____

How would you rate your pain on a scale from 1 to 10? (Please circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 *(Worst Pain Possible)*

Have you ever been to a Podiatrist or Orthopedist before? If so, please provide Name and Reason for Consulting_____

GENERAL MEDICAL HISTORY

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	[ ]Yes [ ]No	Epilepsy	[ ]Yes [ ]No	Diabetes	[ ]Yes [ ]No
Anesthetic Allergies	[ ]Yes [ ]No	Eye Problems	[ ]Yes [ ]No	Lung Disease	[ ]Yes [ ]No
Rheumatic Fever	[ ]Yes [ ]No	Fainting	[ ]Yes [ ]No	Anemia	[ ]Yes [ ]No
Shortness of Breath	[ ]Yes [ ]No	Angina	[ ]Yes [ ]No	Gout	[ ]Yes [ ]No
Arthritis	[ ]Yes [ ]No	Headaches	[ ]Yes [ ]No	Special Diet	[ ]Yes [ ]No
Artificial Heart Valve	[ ]Yes [ ]No	Heart Disease	[ ]Yes [ ]No	Stroke	[ ]Yes [ ]No
Artificial Joint(s)	[ ]Yes [ ]No	Asthma	[ ]Yes [ ]No	Hemophilia	[ ]Yes [ ]No
Ankle/Foot Swelling	[ ]Yes [ ]No	Cancer	[ ]Yes [ ]No	Tired Feet	[ ]Yes [ ]No
High Blood Pressure	[ ]Yes [ ]No	Rash	[ ]Yes [ ]No	Hepatitis	[ ]Yes [ ]No
Kidney Problems	[ ]Yes [ ]No	Neuropathy	[ ]Yes [ ]No	Phlebitis	[ ]Yes [ ]No
Circulatory Problems	[ ]Yes [ ]No	Tuberculosis	[ ]Yes [ ]No	Ulcers	[ ]Yes [ ]No
Venereal Disease	[ ]Yes [ ]No	Ear Problems	[ ]Yes [ ]No	Mitral Valve	[ ]Yes [ ]No

Smoking History [ ] Never [ ] Former [ ] Current -- ____ Packs per day

Surgeries You Have Had_____

Hospitalizations (other than surgeries)_____

Family Physician _____ Last Visit Date_____

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins_____

_____

Pharmacy Name(s)_____Phone No._____

ALLERGIES

[ ] Adhesive Tape [ ] Anticoagulant Therapy [ ] Aspirin [ ] Codeine [ ] Demerol [ ] Iodine

[ ] Local Anesthetics [ ] Novocain [ ] Penicillin [ ] Seafood [ ] Sulfa Drugs

Other Allergies_____