Dr. Kevin Massard D.P.M.

Patient Medical History

Today's Date: _____

Patient Name:_____

Date of Birth: _____

Primary Physician Name: _____ Phone:_____

Address: _____ Last Visit: _____

Current Weight _____Lbs Height _____ Shoe Size _____ Width _____

Chief Complaint: *Why are you visiting today?*

What is the reason for your visit today? _____

Please list any additional foot problems you are concerned about: _____

_____

History of Present Illness: *Tell me more details about your foot or ankle problem.*

When did your symptoms start? _____

Where is the problem located? _____

Do you have pain or disability ☐ No ☐Yes, What is the nature of the pain/disability: ☐ Burning ☐ Aching ☐ Stabbing ☐ Shooting ☐Other, Explain: _____

What causes or makes your problem worse? ☐ Standing ☐Walking ☐ First Steps After Rest ☐ Long Periods on Feet ☐ Other, please explain: _____

Any trauma or injury to the area? ☐ No ☐ Yes, Please Explain: _____

Any self treatment or Dr. related visits for the problem? ☐ No ☐Yes, Please describe: _____

_____

Past Medical History

Have you had any previous major Medical Problems or Injuries? ☐ No ☐Yes, Explain: _____

_____

Have you had any prior Hospitalizations or Operations? ☐ No ☐Yes, Explain: _____

_____

Are you taking any medications or supplements? ☐ No ☐ Yes, please list name, dose & reason for medications:_____

_____

Do you have any allergies: ☐ Medications ☐ Foods ☐ Environmental - Please list Medication allergies and reactions:

_____

Social History

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Education: ☐ Elementary ☐ High School ☐ Some College ☐ College Degree – Occupation _____

Tobacco Use ☐ No ☐ Yes, frequency: _____ Alcohol Use ☐ No ☐ Yes, frequency: _____

Any illness/disease that runs in the family? ☐ No ☐Yes, explain: _____

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Review of Systems
Do you currently have any of the following: (Please check box)

	AIDS or HIV Virus		Dermatitis		Leg Pain with Walking		Sore Throat
	Anemia		Diabetes		Liver Disease Problems		Stiffness
	Arthritis		Dizziness		Loss of Hearing		Stomach Ulcers
	Atherosclerosis		Emphysema		Low/High Blood Pressure		Stroke
	Back Pain		Fainting		Moles		Swelling/Edema
	Birth Marks		Frequent Urination		Muscle Pain		Thyroid Problems
	Bleeding Disorders		Headaches		Numbness		Tuberculosis
	Blocked Arteries		Heart Attack		Persistent Cough		Unquenchable Thirst
	Breathing Difficulties		Heart Murmur		Poor Appetite		Vision Problems
	Bronchitis		Hepatitis A B C		Psoriasis		Weight Gain/Loss
	Cancer		Irregular Heart Beat		Rash		Wheezing
	Chest Pain		Itching		Respiratory problems		
	Circulation Problems		Jaundice		Ringing in Ears		
	Convulsions/Seizures		Joint Pain		RSO		
	Depression		Kidney Disease		Sciatica		
	Any Disease, Illness or Symptoms not listed above, please list:						

Doctors Notes:

Authorization, Release and Assignment of Benefits:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Massard to furnish information including diagnosis and the record of any treatment or examination rendered to me or my child during the period of such Podiatric care to third party payors (Insurance Companies) and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Kevin Massard DPM medical insurance benefits otherwise payable to me. I understand that my medical insurance carrier may pay less than the actual bill for services. I also understand that my insurance may not cover certain treatments or supplies during my visits. I agree to be responsible for payment of all services and supplies rendered on my or my dependents behalf. Including late fees, interest, and cost of collections as allowed by law and set forth in the clinics Financial Policy.

I have read, understand and acknowledge the information above:

X_____ Date _____
Signature of Patient (Parent if Minor)