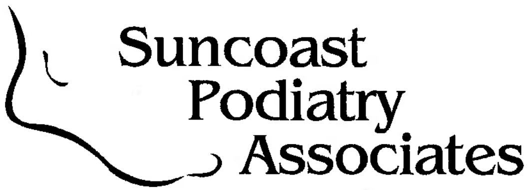


DATE ___________

Stephen R. Miller, DPM

Timothy J. Whyatt, DPM

Ocala
• 3301 S.W. 34th Circle,
Suite 102
Ocala, FL 34474

Telephone:
352-861-0444

Fax:
352-861-0464

Name_________________________________ DOB_____________

ADDRESS: ______________________________________________

CITY:____________________________ STATE:______ZIP:_________

Sex: ____M, _____F Marital Status: ___________________________

EMAIL: ________________________________________________

Phone Number: ________________________Cell or Home (circle one)

PRIMARY INSURANCE:______________________________________

SUBSCRIBER NAME:________________________________________

RELATIONSHIP TO INSURED: ____________________

DOB OF INSURED ________________________

POLICY ID NUMBER: _______________________________________

SECONDARY INSURANCE:______________________________________

SUBSCRIBER NAME:________________________________________

RELATIONSHIP TO INSURED: ____________________

DOB OF INSURED ________________________

POLICY ID NUMBER: _______________________________________

PREFERED PHARMACY ____________________________________

PRIMARY DOCTOR OR FACILITY _______________________________

PATIENT SIGNATURE: ______________________________________

Suncoast
Podiatry
Associates

Date________________

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**Reason for TODAY'S visit?**________________________________________

____________________________________________________________

**How did you hear about us**? Insurance, Primary Doctor, Friend , Google, Other

**1.) Are you a Diabetic?**

*(If yes, answer questions below)*

a.) What size shoe do you wear?

b.) Do you have any numbness in your feet or toes?

c.) Any history of open wounds on your feet or lower legs?

d.) Are you looking to get diabetic shoes?

e.) When did you get your last pair of shoes?

**2.) Do you have or have you had foot pain or ankle pain?**

(If yes, answer questions below)

a.) How long have you had the pain?

b.) Where is the pain?

c) What is your pain level 1 -10? (10 being the highest.)

e) Is this a result of an injury or accident?

f.) Have you had an X-ray or MRI? Where?___________

g.) Do you have swelling?

**3.) Do you have or have you had Heel Pain?**

(If yes, answer questions below)

a.) When does it hurt the most?

b.) What treatments have you tried?

c.) How long has it been bothering you?

PATIENT SIGNATURE: ________________________________________

**4.) Are you here for an ingrown nail?**

(If yes, answer questions below)

a.) What toes are ingrown?

b.) What treatments have you tried?

c.) How long has it been bothering you?

**5.) Are your feet dry?**

**6.) Do you have any lumps on your feet or legs you are concerned about?**

**7.) Are your feet red or itchy?**

**8.) Do you have any swelling?**

**9.) Do you have any other concerns about your feet?**

**Medical History: please circle all problems that you have had:**

Liver Issues Heart murmur Blood Clots Neuropathy Arthritis Alcoholism

Sleep apnea Stomach/bowel High Cholesterol Blood Disorders

Gout Depression Thyroid Disease Circulation problems Allergies

Anxiety High Blood pressure Musculoskeletal Heart Disease Mental Illness

Cancer Diabetic ( Type I, Type II) HIV Skin disorders Breathing Issues

Asthma Kidney Disease Hepatitis CVA Stroke

Other________________________________________________

**Surgical History: Please Circle one**

None Appendectomy C-section Angioplasty Bypass Cataracts
cholecystectomy Other:________________________________

**Any foot or ankle surgery?**

**Any artificial Joints? Where?**

**Any Pacemaker or artificial heart Valve?**

PATIENT SIGNATURE: ________________________________

**Family HIstory: Circle any that applies blood relative**

Alzheimer's Arthritis Bleeding Disorders Blood Clot Cancer Cataracts Circulation problems Depression Diabetes Emphysema Heart Disease High Blood Pressure Neurological Strokes

**Review of Systems: please circle all that applies**

Cardio Vascular: leg pain when walking, fever, chest pain, leg swelling, cold hands and feet, fainting, palpitations, vascular disease, valve problems, NONE

Genitourinary: blood in urine, hesitancy, incontinence, increased urgency, decreased frequency, excessive urination, kidney disease, kidney stones, NONE

Gastourinary: abdominal pain, heartburn, blood in stool, vomiting, ulcers, constipation, diarrhea, trouble swallowing, decreased appetite, increased appetite, NONE

Integumentary: athletes foot, nail abnormalities, keloids, itchiness, dry, scaly skin, NONE

Hematologic: lower leg ulcers, sickle cell disease, anemia, blood thinners, clotting disorders, NONE

Neurological: tingling, weakness, seizures, numbness, headaches, tremors, paralysis, NONE

Musculoskeletal: back pain, joint swelling, muscle weakness, muscle pain, neck pain, sciatica, joint stiffness, joint pain, joint instability, arthritis, NONE

Respiratory: Chest pain, wheezing, COPD, coughing, snoring, shortness of breath, emphysema, NONE

**Social History:**

*Please circle all that applies:* Cigarettes or Cigar: Current Smoker, Never Smoker, Former Smoker

Do you drink alcohol?

*How often? ____________________________________

Do you use recreational drugs?

*How often? ____________________________________

Do you Exercise?

*How often? ____________________________________

What is your Occupation? _____________________________

PATIENT SIGNATURE: ________________________________________

Suncoast
Podiatry
Associates

Date:____________

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Medications & Doses: (*Please list Vitamins also)*

Allergies to medications*: (please include if it's a mild, medium or extreme allergy)*

Patient signature:______________________________