HAROLD M. KOEHLER, DPM

NAME OF PATIENT_____ AGE_____ BIRTHDATE_____

ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE_____ CELL PHONE_____ SS#_____-_____-_____

EMAIL:_____

MARITAL STATUS_____ GENDER: MALE FEMALE

IN CASE OF EMERGENCY WHOM SHOULD WE NOTIFY? _____

EMERGENCY CONTACT PHONE _____ RELATIONSHIP TO PATIENT _____

IF PATIENT IS A MINOR, WHO IS RESPONSIBLE FOR PATIENT? _____

RELATIONSHIP TO PATIENT?_____

OCCUPATION OF PATIENT _____

EMPLOYER NAME, ADDRESS, AND PHONE _____

FAMILY PHYSICIAN/PRIMARY CARE DR _____ PHONE _____

ADDRESS _____

Date last seen by physician: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

1) My family physician, Dr._____
2) Listed in my insurance book _____
3) Recommended by my friend _____
4) Internet_____
5) Other_____

INSURANCE INFORMATION
(Bring cards, we copy)

Primary Insurance:_____ ID# _____ Group #_____
Name of Insured:_____ Date of Birth of Insured:_____
SS# of Insured:_____

Secondary Insurance:_____ ID#_____ Group #_____
Name of Insured:_____ Date of Birth of Insured:_____

I ATTEST THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE FILING.

SIGNED:_____ DATE_____

# HAROLD M. KOEHLER, DPM

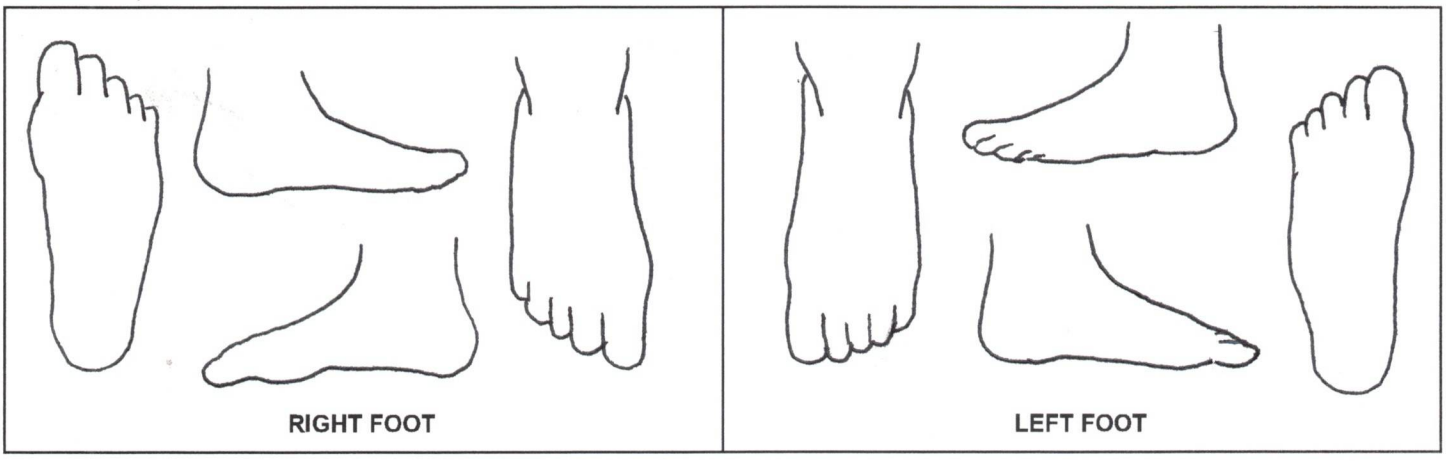
Please describe your foot or ankle problem_____

_____

_____

How long has this been going on? _____ Days/Weeks/Months/Years_____

Where is the pain/problem located? Please mark the pictures below.




How would you characterize the nature of your pain? ____ Sharp ____ Dull ____ Aching ____ Throbbing ____ Burning ____
Numbness ____ Radiating ____ Stabbing ____ Night Pain ____ Other ____

How would you rate your pain on a scale of 0-10? 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What makes the pain worse, e.g. walking, standing, certain types of shoes, sports, work, etc. _____

What makes your pain feel better? _____

List all previous or self treatment you have tried _____

Have you ever worn orthotics/arch supports? _____Yes _____No If yes, _____ Over the counter _____Custom

Have you ever seen a podiatrist before? _____Yes _____ No If yes, for what problem? _____

Please list Dr. name _____ Last seen _____

Do you have any other foot problems you would like to discuss?_____

**SOCIAL HISTORY:** Occupation_____

Does your employment require you to be on your feet a lot of the time or is it mainly sedentary? _____

List athletic activities: _____ How often? _____ Per day/week _____

Current Tobacco use _____Yes _____No #Packs /day _____ How long? _____

Past smoker _____Yes _____ No #Packs /day _____ How long? _____ How Long? _____ Quit _____mo/years ago

Alcohol use _____ None _____Rarely _____ Moderately _____ Daily _____ Daily list quantity _____

History of excess alcohol consumption _____Yes _____ No How long? _____

Recreational drug use _____ None _____ Rarely _____ Moderately _____ Daily List type(s) of drug _____

**FAMILY HISTORY**: Please include any significant medical conditions including diabetes, heart disease, hypertension, stroke, kidney disease, cancer, arthritis, anemia, hypothyroidism, gout

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| RELATIONSHIP | AGE | HEALTH PROBLEMS | AGE AT DEATH | CAUSE OF DEATH |
| FATHER | | | | |
| MOTHER | | | | |
| SIBLINGS | | | | |
| | | | | |
| | | | | |
| | | | | |

What is your age _____ Height _____ Weight _____

Are you currently under the care of a doctor _____ Yes _____ No Last Visit _____

Doctor's name _____ Address _____

Please list all other doctors or specialists you are seeing

_____

**PRESENT MEDICAL HISTORY** Please list any known medical problems you have at present

| Medical Problem | Date of onset | Medical Problem | Date of onset |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**LIST ALL PREVIOUS PROCEDURES & HOSPITALIZATIONS** If you do not remember the exact dates, please estimate

Surgical History Date Hospital stay/reason Date

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any artificial joints? Where? _____

Do you have any anesthesia complications? _____Yes _____No

MEDICATIONS: List all medications/reasons, vitamins and nutritional supplements you are currently taking (Please bring list, we can copy)

| MEDICATION | MEDICATION | MEDICATION | MEDICATION |
|---|---|---|---|
| 1. | 5. | 9. | 13. |
| 2. | 6. | 10. | 14. |
| 3. | 7. | 11. | 15. |
| 4. | 8. | 12. | 16. |

**DRUG ALLERGIES**: Please list drug and reaction

_____

_____

Any reaction to local anesthetics, lates, tape or iodine? _____

**REVIEW OF SYSTEMS:** Check all that apply

**GENERAL:**
☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Weakness or fatigue ☐ Fainting ☐ Night sweat ☐ Fever ☐ Any type of Cancer

**NEUROLOGIC:**
☐ Seizures ☐ Inability to detect hor or cold ☐ Inability to detect pain ☐ Complex regional pain syndrome (RSD) ☐ Paralysis

☐ Numbness ☐ Tingling in hands or feet ☐ Weakness ☐ Abnormal sensation ☐ Burning in feet

**CARDIOVASCULAR:**
☐ Blood clots ☐ Irregular heart beat ☐ Swellling in ankles ☐ Pain in calves or thighs when walking ☐ High blood cholesterol or triglicerides

☐ High blood pressure ☐ Poor circulation ☐ Swelling in the legs ☐ Heart murmurs ☐ Phlebitis ☐ Chest pain ☐ Varicose veins

☐ Shortness of breath ☐ Rheumatic fever

**GASTROINTESTINAL:**
☐ Gastric or peptic ulcers ☐ Stomach pain ☐ Liver or gallbladder trouble ☐ Wheat or gluten intolerance ☐ Indigestion ☐ Heartburn

☐ Hepatitis ☐ Milk intolerance ☐ Nausea ☐ Cirrhosis ☐ Jaundice ☐ Food intolerance

**MUSCULOSKELETAL:**
☐ Joint stiffness in the morning ☐ Weakness in legs ☐ History of osteoporosis ☐ Rheumatoid arthritis ☐ Back or spine problems

☐ History of herniated disks ☐ Unexplained pain in many areas of the body ☐ Joint or pain swelling ☐ Artificial joints ☐ Osteoarthritis

☐ Fractures ☐ Vetebral fracture ☐ Chronic fatigue syndrome ☐ Muscle weakness ☐ Swollen joints ☐ Arthritis ☐ Spinal stenosis

☐ Fibromyalgia ☐ Gout

**IMMUNOLOGY:**
☐ Mononucleosis ☐ Multiple Sclerosis ☐ Any autoimmune disorders such as lupus, scleroderma, or rheumatoid arthritis

**ENDOCRINE:**
☐ Thyroid disease ☐ History of recent use of steroids ☐ Diabetes ☐ Recent weight changes ☐ Hyperparathyroidism ☐ Excessive thirst

**SKIN:**
☐ Easy bruising ☐ Eczema ☐ Keloids ☐ Scaling ☐ Painful corns and calluses ☐ Shingles ☐ Contact dermatitis ☐ Hives ☐ Psoriasis

☐ Plantar warts ☐ Sores that will not heal ☐ Fungal infections ☐ Toenail fungus ☐ Excessive scarring ☐ Rashes ☐ Change in moles

☐ Itching ☐ Athletes foot ☐ Ingrown toenails ☐ Skin cancer

**HEMATOLOGIC:**
☐ Anemia ☐ Sickle cell anemia ☐ Abnormal bleeding with surgery ☐ Easy bruising ☐ Past transfusions ☐ Bleeding disorders

☐ Bleeding ☐ Blood clots

# APPOINTMENT POLICY

YOUR ACCOUNT WILL BE CHARGED A FULL OFFICE VISIT OR A NO SHOW FEE FOR MISSED APPOINTMENTS AND NOT CALLING TO CANCEL PRIOR TO YOUR VISIT AT LEAST 24 HOURS

YOU ARE TAKING ANOTHER PERSONS APPOINTMENT IF YOU DON'T SHOW UP OR CALL TO CANCEL.

Please sign:_____

## PHARMACY NAME AND INFORMATION FOR THE OFFICE

Name of your pharmacy_____

Pharmacy phone #_____

Pharmacy address and city_____

_____