HAMILTON FOOT AND ANKLE ASSOCIATES

Date: _____

Name:_____ Date of Birth:_____ Age:_____

Address:_____ APT# _____ Social Security #:_____

City:_____ State:_____ Zip Code:_____ Telephone Number:_____

E-Mail Address:_____ Cell Phone #_____

Occupation:_____ Employed By:_____

Employer Address:_____ Telephone Number:_____

Family Physican:_____ Address:_____

Whom may we thank for referring you to our office?_____

What is the chief problem for which you came to be treated?_____

_____

_____

_____

Are you now, or have been under any other Doctor's care for any reason over the past 2 years?.
YES_____ No_____
If yes, please explain_____
_____

Are you Allergic to:
☐Local Anesthetics ☐Adhesive Tape ☐Seafood ☐Penicillin ☐Aspirin
☐Other_____

Are you taking any medications or drugs at this time? (Include vitamins and all over the counter preparations):
_____

_____

Have you ever been treated for any of the following:
☐ Heart Problems ☐Phlebitis ☐Rheumatic Fever ☐Asthma ☐Diabetes
☐ Cancer ☐Liver Problems ☐ Gout ☐Arthritis Height_____
☐High or Low Blood Pressure ☐ Kidney Problems ☐Bleeding Disorders Weight_____

Have you ever fainted in a Doctor's office?_____