

Dr. Charles S. Yarnevich Medical & Surgical Podiatrist

PLEASE PRINT CLEARLY

PATIENT'S NAME _____ AGE _____ DATE OF BIRTH _____
First Middle Last

RESIDENCE PHONE _____ S. S. NO. _____ MARITAL STATUS _____

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

PRIMARY CARE PHYSICIAN _____ E-MAIL _____

EMPLOYED BY _____ BUSINESS PHONE _____ OCCUPATION _____

NAME OF SPOUSE _____ DATE OF BIRTH _____ S. S. NO. _____

EMPLOYED BY _____ BUSINESS PHONE _____ OCCUPATION _____

CONTACT PERSON _____ RELATIONSHIP _____ PHONE _____

IF A MINOR - FATHERS NAME _____ D O B _____ ADDRESS _____ PHONE _____
 MOTHERS NAME _____ D O B _____ ADDRESS _____ PHONE _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

WHO REFERRED YOU TO OUR OFFICE _____ ARE YOU A PREVIOUS PATIENT OF THIS OFFICE? _____

HAS ANY MEMBER OF YOUR FAMILY BEEN OUR PATIENT? _____ THE PATIENT'S NAME _____

FORMER PODIATRIST _____ APPROXIMATE DATE OF LAST VISIT _____

WHAT IS YOUR PRESENT FOOT PROBLEM? _____

PLEASE ANSWER EACH QUESTION

		YES	NO
1 ARE YOU IN GOOD HEALTH?		<input type="checkbox"/>	<input type="checkbox"/>
2 ARE YOU NOW OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST TWO YEARS?		<input type="checkbox"/>	<input type="checkbox"/>
3 ARE YOU SUBJECT TO NERVOUS DISORDERS, FAINTING OR DIZZINESS?		<input type="checkbox"/>	<input type="checkbox"/>
4 ARE YOU SUBJECT TO PROLONGED BLEEDING AFTER TOOTH EXTRACTION OR CUTS?		<input type="checkbox"/>	<input type="checkbox"/>
5 HAVE YOU EVER EXPERIENCED ANY ILL EFFECTS FROM NOVOCAINE, PENICILLIN OR ANY OTHER DRUGS?		<input type="checkbox"/>	<input type="checkbox"/>
6 HAVE YOU EVER HAD ANY ALLERGIES?		<input type="checkbox"/>	<input type="checkbox"/>
7 HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING:			
DIABETES	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	
RHEUMATIC FEVER	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY AILMENT	<input type="checkbox"/>	<input type="checkbox"/>	
LIVER AILMENT	<input type="checkbox"/>	<input type="checkbox"/>	
8 HAVE YOU EVER HAD CORTISONE THERAPY?		<input type="checkbox"/>	<input type="checkbox"/>
9 ARE YOU PREGNANT?		<input type="checkbox"/>	<input type="checkbox"/>
10 HAVE YOU HAD ANY INJURIES OR OPERATIONS ON YOUR FEET OR LEGS?		<input type="checkbox"/>	<input type="checkbox"/>
11 HAVE YOU EVER EXPERIENCED AN UNFAVORABLE REACTION FROM ANY PREVIOUS PODIATRIC TREATMENT?		<input type="checkbox"/>	<input type="checkbox"/>
12 IS THERE ANY OTHER INFORMATION ABOUT YOUR HEALTH WHICH SHOULD BE KNOWN?		<input type="checkbox"/>	<input type="checkbox"/>

EXPLAIN _____

DATE _____ PATIENT SIGNATURE _____
PARENT, IF A MINOR