6300 Regional Plaza, Suite 260
Abilene, TX 79606

Martin V. Sloan, DPM
Diplomate, American Board of Podiatric Surgery
Board Certified in Foot Surgery

325.695.1890
325.695.1665 (fax)
www.DrMartinSloan.com

Patient Information

Patient's Name ____ Telephone ________________________

Home Address ____________________________________ City _______________ State _____ Zip_________

Date of Birth ____________ Age ____ Social Security No. ____-___-____ Driver's License No _____________

Sex: M / F Marital Status: S M D Sep W Email Address ____________________________________

Patient Employed by ________________________________ Occupation __________________________________

Business Address __________________________________ Business Phone ____________________________

Next of Kin ____ Employed by ______________________________

Business Address __________________________________ Business Phone ____________________________

Who referred you to this office? Name __________________________ Address ___________________________

What pharmacy do you use? ____

Insurance, Medicare Information

Company or Program	Insured SS# / ID #	Group	Date of Birth (insured)

Authorization

__ Yes __ No I hereby authorize benefits directly to the physician of the surgical and/or medical benefits

__ Yes __ No I also understand I am responsible for any portion of my bill not covered by the insurance company

__ Yes __ No I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES

__ Yes __ No The information authorized for release may include information which may be considered communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV or AIDS

I understand all of the above and hereby state that the information is correct to the best of my knowledge

____________________________________ ________________ ________________________________
Signature of Responsible Party if Other Than Patient Date Signature of Patient

Medical Information

Physician ________________________________ City ________________ Last Visit ________

Physician ________________________________ City ________________ Last Visit ________

Are you now, or have you been under a physician's care during the past 2 years? Yes No

Date of last complete physician examination ______________

Are you under active care for diabetes? ☐ YES ☐ NO Circulation Problems? ☐ YES ☐ NO

If so, doctor's name ______________________________ Last seen _______________________

Insulin Dependent ☐ YES ☐ NO Diet Controlled ☐ YES ☐ NO

No. years diabetic _________ Avg Blood Sugar Range ______

Review of Systems (check each item that applies to you)

CONSTITUTIONAL (GENERAL)

____ Weight loss/over 10 lbs	____ Weight gain/over 15 lbs	____ Fever	____ Chills
____ Fatigue	____ Nausea	____ Other _________________	

EYES, EARS, NOSE & THROAT

____ Impaired sight	____ Eye disease	____ Eye pain	____ Vision problem
____ Eye infections-frequent	____ Glaucoma	____ Hearing loss	____ Ringing in ears
____ Ear infections	____ Dizzy spells	____ Fainting spells	____ Nose bleeds-frequent
____ Breathing difficulty	____ Sinus problems	____ Sore throat	____ Hoarseness
____ Speech difficulties	____ Dental problems	____ Abscessed (infected) teeth	
____ Other __________________			

RESPIRATORY

____ Pneumonia/Pleurisy	____ Bronchitis/Chronic cough	____ Asthma/Wheezing	____ Shortness of breath
____ Tuberculosis	____ Emphysema	____ Hay fever/Allergies	____ Limited exercise tolerance
____ Use oxygen at home	____ C.O.P.D.	____ History of smoking	____ Other ______________

CARDIOVASCULAR

____ Chest pain	____ Heart attack	____ High blood pressure	____ Open-heart surgery
____ Heart murmur	____ Chronic swelling ankles/feet	____ Palpitations	____ Irregular beat/pulse
____ Pacemaker	____ Mitral valve prolapse	____ Angioplasty	____ Artificial heart valve
____ Rheumatic fever	____ Circulation disorder	____ High cholesterol	____ Leg pain/walking
____ Leg pain/at rest	____ Tiredness in legs	____ Varicose vein	____ Phlebitis
____ Blocked arteries	____ Cold, numb feet	____ Angina - increased occurrence	
____ Angina-increased intensity	____ Angina-new onset at rest	____ Change in chest pain pattern	

_____ Cardiac occlusive disease
_____ Congestive heart failure
_____ Other ______________________

GASTROINTESTINAL

_____	Loss of appetite	_____	Excessive hunger	_____	Excessive thirst	_____	Difficulty swallowing
_____	Heart burn	_____	Peptic ulcer	_____	Persistent nausea	_____	Vomiting
_____	Abdominal pain/chronic	_____	Gallbladder problem	_____	Liver problem	_____	Jaundice
_____	Hepatitis A	_____	Hepatitis B	_____	Hepatitis C	_____	Cirrhosis
_____	Diarrhea	_____	Diverticulosis	_____	Crohn's/colitis	_____	Bloody or black stools
_____	Heartburn/Refulx esophagitis	_____	Other ______________________				

BLADDER, KIDNEY

_____	Frequent urination	_____	Bladder infections-frequent	_____	Blood in urine	_____	Kidney stone
_____	Renal failure	_____	Swelling feet				

FEMALE

_____	Sexual transmissive disease	_____	Breast cancer	_____	Ovarian cancer
_____	Postmenopausal	_____	Oral contraceptives		

MALE

_____ Sexual transmissive disease
_____ Prostate cancer

HEMATOLOGIC (BLOOD DISORDERS)

_____	Anemia	_____	Bruise easily	_____	Cancer	_____	Blood transfusion
_____	Sickle cell disease/trait	_____	Take Coumadin				

ENDOCRINE

_____ Diabetes
_____ Thyroid disease
_____ Other ______________________

NEUROLOGICAL (NERVOUS)

_____	Seizures	_____	Tremor/hands shake	_____	Headaches-frequent	_____	Stroke
_____	Change in memory	_____	Trouble with balance	_____	Spine disease	_____	Sciatica
_____	Numbness	_____	Muscle weakness	_____	Polio	_____	Change in sensation

BONE AND JOINT

_____ Arthritis/Rheumatism
_____ Back pain-recurrent
_____ Gout
_____ Osteoporosis

_____ Osteoarthritis
_____ Rheumatoid arthritis
_____ Artificial joints ____________________
_____ Severe arthritis of TMJ (jaw) or neck

SKIN

_____ Rashes	_____ Hives	_____ Psoriasis	_____ Eczema
_____ Skin cancer	_____ New growths	_____ Color change-mole/wart	
_____ Thick scar or keloid formation	_____ Other ______________________		

PSYCHIATRIC

_____ Sleeping difficulty	_____ Concentration difficulty	_____ Depression	_____ Nervousness
_____ Agitation	_____ Memory loss	_____ Moodiness	_____ Suicidal thoughts
_____ Phobias	_____ Mental illness	_____ Feelings of worthlessness	

CHILDHOOD ILLNESS

_____ Rheumatic fever	_____ Scarlet fever	_____ Chickenpox	_____ Mumps
_____ Measles	_____ Herpes		

ALLERGY/IMMUNOLOGY

_____ Hay fever	_____ Grass, mold, dust	_____ Food allergies	_____ HIV
_____ Weak immune system	_____ Chronic fatigue syndromes	_____ Frequent infections	

HIV positive? _____ Yes _____ No Any infection/past 6 months? _____ Yes _____ No

Hepatitis _____ Yes _____ No Other (please specify) __________________________

Wound healing history ____

Do you have any artificial joints? Hip ___ Knee Other ________________________

Do you have a heart valve implant? _____ Yes _____ No

PLEASE CIRCLE ANY KNOWN ALLERGIES

Penicillin	Novocain	Codeine	Local anesthesia	Tape
Murcurials	Sulfa drugs	Aspirin	Other antibiotics	None

Other known allergies ____

PLEASE LIST ANY MEDICATIONS NOW BEING TAKEN (WITH DOSAGE)

Name of Medicine	Reason For Taking It	How Often Do You Take It?

Have you taken Prednisone over the past 6 months? ___ Yes ___ No

PREVIOUS SURGERIES (WITH APPROXIMATE DATES)

FAMILY MEDICAL HISTORY

Mother	____	Living	____	Deceased	Cause of death ____________________
Father	____	Living	____	Deceased	Cause of death ____________________
Brother	____	Living	____	Deceased	Cause of death ____________________
Sister	____	Living	____	Deceased	Cause of death ____________________

Has anyone in your family ever been treated for:

	You	Father	Mother	Brother	Sister	Children	Grandparents	Aunt/Uncle
Arthritis	____	____	____	____	____	____	____	____
Cancer	____	____	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____	____	____
Foot problems	____	____	____	____	____	____	____	____
Gout	____	____	____	____	____	____	____	____
Neuromuscular disease	____	____	____	____	____	____	____	____
Peripheral vascular disease	____	____	____	____	____	____	____	____
Tuberculosis	____	____	____	____	____	____	____	____
Varicose veins	____	____	____	____	____	____	____	____
Heart disease	____	____	____	____	____	____	____	____
Bleeding disorder	____	____	____	____	____	____	____	____
Stroke	____	____	____	____	____	____	____	____

Do you smoke? ___ Yes ___ No No. packs per day __________

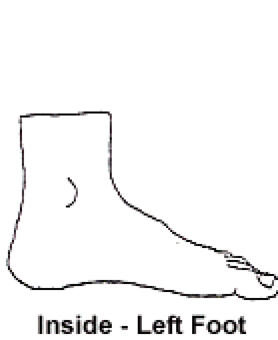
Previously smoked? ___ Yes ___ No No. of years _______________

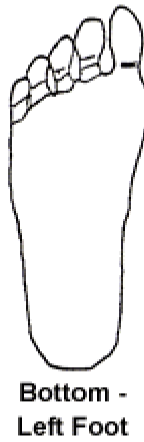
Do you drink alcohol or beer? ___ Yes ___ No

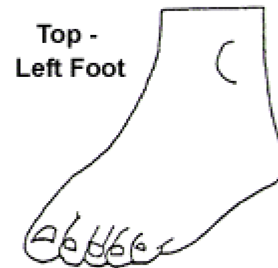
If yes, how much ___ 1-2/week ___ 1-2/day ___ more than 2 daily

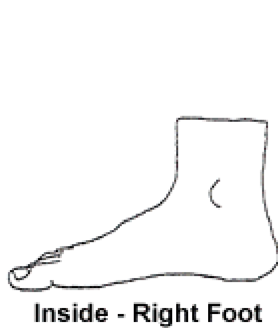
DESCRIPTION OF PROBLEM

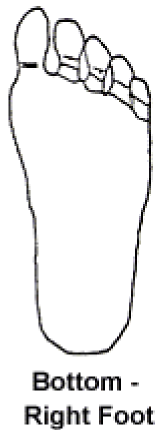
On the diagrams below, please mark the place(s) where you are experiencing pain in your feet:

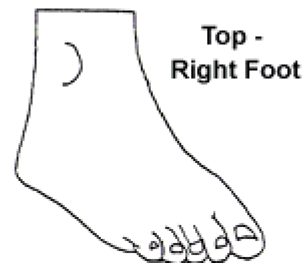












Regarding the place(s) you marked above, describe the pain you experience, for instance, mild, moderate, severe, throbbing, burning, etc. and the time of day it occurs:

____

____

____

DESCRIPTION OF PROBLEM (CONTINUED)

What is your foot problem? ____

____

How long have you been bothered by foot problems? ____

How would you describe the pain you are having ____

____

How is this condition limiting your activities? ____

____

Have you seen another doctor for your foot problems? _______________

Did you see a foot doctor or a family doctor? _______________________

Name of previous doctor who treated your foot problem ____

EMPLOYMENT HISTORY OF SHOES:

Employment: ___ sits at job ___ stands at job ___ stands & walks at job ___ retired

Does the employer require any particular type of shoes? Boots ___ Heels _____ Other ___ N/A __

After work: ___ goes home and sits ___ goes home and exercises Type of exercise ___________________

Length of time _____________________

Current weight _________________ Current height ________________

____ ___________________________________

Signature Date