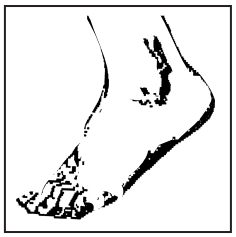
SURGICAL FOOT SPECIALITIES, P.A.

DERYCK FERNANDEZ, D.P.M.
FOOT AND ANKLE SURGEON

8190 Royal Palm Blvd., Suite 203
Coral Springs, FL 33065
Phone 954-346-5044
Fax 954-346-5078



DATE: _____

INSURANCE: _____

SOCIAL SECURITY NO_____

RACE (circle) Asian/Black/Hispanic/White/Other_____

FULL NAME _____ AGE ____ DATE OF BIRTH _____

ADDRESS _____CITY _____ STATE ____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____ OCCUPATION _____

EMERGENCY CONTACT, RELATIONSHIP, PHONE NO _____

EMAIL ADDRESS: _____ Is foot/ankle problem a work injury? _____

WHAT IS YOUR CURRENT FOOT PROBLEM? (include which foot, toe, area) _____

_____

PRIMARY MEDICAL DOCTOR, ADDRESS, PHONE NO _____

_____ Date of Last Visit with PCP _____

GENERAL HEALTH - If you had or now have any of the following, please check below:_____

( ) Anemia
( ) Asthma/Bronchial
( ) Arthritis
( ) Bleeding Disorder/Hemophiliac
( ) Cerebral Accidents- Stroke
( ) Diabetes (insulin or non Insulin)
( ) Emphysema
( ) Epilepsy
( ) Gl Disorders-Ulcer/Hiatal Hernia
( ) Glaucoma
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) HIV/AIDS
( ) Hypertension/High Blood Pressure
( ) Hypotension/Low Blood Pressure
( ) Hyperthyroidism/Overactive Thyroid
( ) Hypothyroidism/Underactive Thyroid
( ) Keloids-Hypertrophic Scars
( ) Malignancy _____
( ) Peripheral Vascular Disease
( ) Phlebitis
( ) Renal Disease
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Sickle Cell
( ) Tuberculosis

Other_____

PLEASE LIST CURRENT MEDICATIONS_____

DO YOU SMOKE? No _____ Yes _____ IF YES, HOW LONG? _____

ALLERGIES (Please check)

( ) Adhesive Tape ( ) Codeine ( ) Novocaine/Local Anesthetics ( ) Sulfa
( ) Betadine ( ) Cortisone ( ) Other Antibiotics _____ ( ) Penicillin

( )Other _____

PLEASE LIST SERIOUS ILLNESSES, OPERATIONS, INJURIES (include foot surgery) _____

_____

HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? _____ WHEN WAS YOUR LAST VISIT? _____

FAMILY HISTORY (If immediate family member has or had one of the following, please check)

( ) Arthritis ( ) Diabetes ( ) Hypertension/High Blood Pressure
( ) Asthma ( ) Gout ( ) Peripheral Vascular Disease
( ) Cancer ( ) Heart Disease ( ) Other

_____

TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND BY MY SIGNATURE BELOW, I CONSENT TO TREATMENT FOR MY FOOT AND ANKLE PROBLEMS: (If patient is a minor, parent/legal guardian must sign)

Signature: _____ Date:_____