QUINCY FAMILY FOOT CARE, P.C.

601 S. 8th Street
QUINCY, IL 62301
(217)222-6266

LINDA R. WENSING, DPM
BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS AND PRIMARY PODIATRIC MEDICINE

THOMAS J. WENSING, DPM

Patient Information

Welcome to our office. Your foot care is very important to us.

Patient Name: _____ Today's Date: _____
LAST FIRST MI

Patient Address: _____
STREET CITY STATE ZIP CODE

Home Phone Number: _____Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

Birthdate: _____ Sex: M_____ F _____

Height ____Weight _____Shoe Size ____Email Address:_____

Name of Primary Physician: _____ Date of last exam: _____

How did you hear about our office?
Friend _____ Phone Book _____ Internet _____ Other _____

Insurance information

Please present your insurance card(s) upon registering

Name of Primary Insurance: _____ Employer: _____
Insured's Name: _____ Birthdate: _____SS# _____
Relationship to Patient: Self _____ Spouse _____ Child _____

Name of Secondary Insurance: _____ Employer: _____
Insured's Name: _____ Birthdate: _____ SS# _____
Relationship to Patient: Self _____ Spouse _____ Child _____

Please read and sign

To the best of my knowledge, the questions on this form have been accurately answered.
I understand that I am financially responsible for all charges for services and treatment rendered, including the balance remaining after payment of possible insurance benefits.
I authorize payment of medical benefits to Quincy Family Foot Care, P.C.
I authorize the release of any medical information necessary to process my claims.
No original records or X-Rays will be released from this office. If a copy is desired, a reasonable fee will be assessed.

_____ _____
Signature of Patient, Parent or Guardian Date

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Linda R. Wensing, DPM **Thomas J. Wensing, DPM**

Welcome to our practice. Your foot care is very important to us.

Patient Name: _____ Birthdate: _____ Date: _____

History of Present Illness

Please describe your foot problem and reason for visit: _____

_____

Have you been treated for this problem before? ___yes ____no If yes, what has been done and by whom?

_____

_____

Past Medical/Family History (please check any of the following of which you or your family have been or are being treated)
Be specific: Mother=(M) Father=(F) Sister=(S) Brother=(B)

	Self	Family		Self	Family		Self	Family
Alzheimers/dementia	___	___	Diabetes	___	___	Liver Disease	___	___
Anemia	___	___	Family Foot Problems (list)			Mitral Valve Prolapse	___	___
			_____		___	Neuropathy	___	___
Arthritis (type)_____	___	___	Gout	___	___	Osteoporosis	___	___
Asthma	___	___	Heart Disease	___	___	Peripheral Vascular Disease	___	___
Back trouble	___	___	Hepatitis	___	___	Stomach Ulcer	___	___
Bleeding Tendency	___	___	High Blood Pressure	___	___	Stroke	___	___
Blood Clots	___	___	HIV + or AIDS	___	___	Thyroid Disease	___	___
Blood or plasma Transfusions	___	___	Kidney Disease	___	___	Tuberculosis	___	___
Cancer (where)_____	___	___	Low Blood Pressure	___	___	Other (specify)_____		

Previous Hospitalizations/Surgeries/Serious Illnesses **When?** **Hospital, City, State**

_____

_____

_____

Medications: (include over the counter): _____

_____

Allergies (please check if history of skin reaction or other adverse reaction)

None	___	Latex	___	Sulfa	___
Adhesive Tape	___	Demerol	___	Tetanus antitoxin	___
Aspirin	___	Novocaine	___	Other drugs/medications:	
Iodine	___	Penicillin	___	_____	

Patient social history:

Marital status: Single_____Married_____Divorced_____Widowed_____Child_____

Use of alcohol: Never_____Rarely_____Moderate_____Daily_____

Use of tobacco: Never_____Previously, but quit_____Current packs/day:_____

Occupation: _____

Fitness Activities_____How often?_____

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Review of Systems: Please indicate any <u>PERSONAL</u> history below:

Constitutional Symptoms		**Gastrointestinal**		**Neurological**	
Good general health lately	no yes	Loss of appetite	no yes	Frequent/recurring headaches	no yes
Recent weight change	no yes	Nausea or vomiting	no yes	Light headed or dizzy	no yes
Fever	no yes	Abdominal pain	no yes	Convulsions or seizures	no yes
Fatigue	no yes			Numbness/tingling sensations	no yes
		Genitourinary		Tremors	no yes
Eyes		Kidney stones	no yes	Paralysis	no yes
Eye disease or injury	no yes			Head injury	no yes
Wear glasses/contact lenses	no yes	**Musculoskeletal**			
Blurred or double vision	no yes	Joint pain	no yes	**Psychiatric**	
		Joint stiffness/swelling	no yes	Memory loss or confusion	no yes
Ears/Nose/Mouth/Throat		Weakness of muscles, joints	no yes	Nervousness	no yes
Hearing loss or ringing	no yes	Muscle pain or cramps	no yes	Depression	no yes
Mouth sore	no yes	Back pain	no yes	Insomnia	no yes
Swollen glands in neck	no yes	Cold extremities	no yes		
		Difficulty walking	no yes	**Hematologic/Lymphatic**	
Cardiovascular				Slow to heal after cuts	no yes
Heart trouble	no yes	**Integumentary (skin)**		Bleeding or bruising tendency	no yes
Chest pain or angina pectoris	no yes	Rash or itching	no yes	Anemia	no yes
Palpitation	no yes	Change in skin color	no yes	Phlebitis	no yes
Shortness of breath	no yes	Change in hair or nails	no yes	Past transfusion	no yes
Swelling of feet, ankles, hands	no yes	Varicose veins	no yes	Enlarged glands	no yes
Respiratory		**Endocrine**			
Chronic or frequent coughs	no yes	Gout	no yes		
Spitting up blood	no yes	Excessive thirst or urination	no yes		
Shortness of breath	no yes	Heat or cold intolerance	no yes		
Wheezing	no yes	Skin becoming dryer	no yes		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date