

Limons Foot & Ankle Care
Welcome To Our Office

4614 26th St., West
Bradenton, FL 34207
Tel.: (941)756-6906
Fax: (941)751-0976

11065 Gatewood Drive, Unit 102
Lakewood Ranch, FL 34211
Tel.: (941)782-8639
Fax: (941)243-3605

Patient Account Number: _____

Name of patient: _____ (Circle One) Mr. Mrs. Ms. Miss. Dr.
Last First Middle Initial

Marital Status: (Circle One) Married Single Widowed Divorced Date of Birth: _____

Race: _____ Ethnicity: _____ Patients E-mail: _____

Social Security: _____ Home Phone: _____ Cell Phone: _____

Primary Address: _____
Street Address City State Zip

Secondary Address: _____
Street Address City State Zip

Which address is listed with your Insurance? (Circle One) Primary Secondary

Referred by: _____ Primary Care: _____ Phone: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Employment: (Circle One) Full Time Part Time Unemployed Retired Employers Name: _____

Employers Address: _____ Work Phone: _____

Student: (Circle One) Full Time Part Time Schools Name: _____ Grade: _____

Name of Husband, Wife, Parent or Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Insurance: _____ Subscriber (Insured) Name: _____

Subscriber Social Security: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____ Subscriber Employer Work Number: _____

Subscriber Employer Address: _____

Patients Relationship to Insured: (Circle One) Self Spouse Significant Other Child

Secondary Insurance: _____ Subscriber (Insured) Name: _____

Patients Signature: _____ Date: _____

LIMONS FOOT & ANKLE CARE

Patient Name: _____ Birth date: _____ Account Number: _____

Reason for visit: _____

_____ Date of onset _____

Former Podiatrist: _____ Date last seen: _____

Medical History (check only those items that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Diabetes
diet/oral insulin ___yr | <input type="checkbox"/> GI Ulcers | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Eye pathology | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Charcot joint | <input type="checkbox"/> Stint |
| <input type="checkbox"/> Peripheral vascular dis. | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Leg cramps/numbness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Arthritis:
Rheumatoid/Osteo | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Gout |
| | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Osteomyelitis |
| | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Joint /Muscle Pain | |

Other Medical problems (please list) _____

Surgical History (check only those items that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Arterial by-pass sx | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Breast
biopsy/lumpectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart by-pass | <input type="checkbox"/> Kidney stone sx | <input type="checkbox"/> Back surgery |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Open heart sx | <input type="checkbox"/> Kidney removal | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker/Defibrillator | |
| <input type="checkbox"/> Carotid artery sx | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Gall bladder sx | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Prostate sx | |
| <input type="checkbox"/> D and C | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Venous ligation | |

Other Surgery (please list) _____

Medications (please list) _____

Allergies (please check)

- | | | | |
|-----------------------------------|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Novocain | <input type="checkbox"/> Codeine | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Other _____ |

Reaction: _____

Family History (please circle if positive)

	<u>Diabetes</u>	<u>Heart disease</u>	<u>Cancer</u>	<u>High blood pressure</u>
<u>Mother</u>	yes	yes	yes	yes
<u>Father</u>	yes	yes	yes	yes
<u>Siblings</u>	yes	yes	yes	yes

HOSPICE CARE: Are you CURRENTLY under the care of Hospice Yes- No Date put in Hospice: _____

Social History (please check)

- | | | |
|-------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco ___ppd | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Activities | _____ | |

SIGNATURE: _____ DATE: _____