What is your foot problem? _____

How long have you been bothered by foot problems? _____

What have you done for your foot problems? _____

PAST MEDICAL HISTORY

Family doctor's name _____Address_____

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

Date of last complete physical exam _____

Are you currently taking any medications? (Yes) (No) If yes, please list on attached current medication sheet.

Check if you now have or ever have been treated for: (Check if Yes)

High Blood Pressure ( )	Sickle Cell Anemia ( )	Kidney Problems ( )	Diabetes ( )	Rheumatic Fever ( )
Low Blood Pressure ( )	Foot Problems ( )	Arthritis ( )	Skin Problems ( )	Stomach Ulcer ( )
Glaucoma ( )	Broken Bones ( )	Gout ( )	Bleeding Disorder ( )	Alzheimer's or Dementia ( )
Chronic Pain ( )	Stroke ( )	Anemia ( )	Edema ( )	Liver Problems ( )
Thyroid ( )	Heart disease ( )	Seizure Disorders ( )	Tuberculosis ( )	Epilepsy ( )
Hyperlipidemia ( )	Cancer ( )_____	Sleep Apnea ( )	Asthma ( )	Anxiety or Depression ( )

Have you ever had any other serious illness or operation? _____

_____

Have you ever experienced any unusual or allergic reactions to any of the following? (Check if Yes)

Penicillin ( )	Iodine ( )	Codeine ( )	Aspirin ( )	NSAIDS ( )	Sulphur Drugs ( )	Local Anesthetics ( )
Cortisone ( )	Insulin ( )	Demerol ( )	Novacaine ( )	Antibiotics( )	Tape ( )	Ace Inhibitors ( )

Do you drink alcohol? (Yes) (No) If yes, how much? _____Do you smoke? (Yes) (No) If yes, how much?_____

Do you consume caffeine? (Yes) (No) Coffee, Tea, Soda, Caffeine Drinks

AUTHORIZATION AND AGREEMENTS FOR TREATMENT

1. Consent to Treatment – I understand that medical treatment will be performed by the physicians and employees of this office. I hereby grant my authorization and consent to such treatments and procedures and certify that no guarantee has been made as to results of treatment or procedures.
2. For and in consideration of care and treatment provided to the patient, I will pay the office for all charges for services rendered to or in behalf of the patient which are not covered by the insurance payment.
3. Release of medical information – I hereby authorize the office to release any medical information in connection with these services to any or all of the following:
    1. Health Insurance Companies.
    2. Patient's employer in the event of a worker's compensation injury.
4. I acknowledge that all professional services are provided by physicians who are independent contractors and are employees or agents of the clinic.
5. I hereby authorize payment of medical benefits to Ray W. Ng, D.P.M., P.A.

I have read and fully understand the above acknowledgements and agreements.

Signature _____ Date:_____

Witness _____ Relationship to Patient: _____