

**Bradley S. Ross. D.P.M., P.C.**  
Podiatrist/Foot Specialist  
7126 N. Lincoln Ave, Lincolnwood, IL 60712  
Ph: 847.673.1818 Fax: 847.673.2639

(Please complete as fully as possible)

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Spouse \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Birth Assigned Sex: M F Gender \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

E-mail \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Medical Doctor's Name \_\_\_\_\_ Hospital \_\_\_\_\_

Medications \_\_\_\_\_ Pharmacy Name & City \_\_\_\_\_

I have or have had the following: (please check all that apply)

- |                                       |                                   |                                     |  |
|---------------------------------------|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Tumors            |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Gout       | <input type="checkbox"/> Varicose veins    |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Cancer   | <input type="checkbox"/> GI Ulcers  | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Polio      | <input type="checkbox"/> Heart trouble     |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> TB       | <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> Kidney trouble    |

Other: \_\_\_\_\_

Illnesses in your family? \_\_\_\_\_

List all allergies to medications \_\_\_\_\_

Do you smoke? No \_\_\_\_\_ Quit \_\_\_\_\_ years ago Yes \_\_\_\_\_ Amount/per day \_\_\_\_\_ Number of years \_\_\_\_\_

Do you consume alcohol? Socially \_\_\_\_\_ Daily \_\_\_\_\_ Amount/type \_\_\_\_\_

List past surgeries \_\_\_\_\_

I hereby give permission to Dr. Bradley Ross to examine and treat my feet and to perform such diagnostic procedures and treatments as may be deemed necessary. I further authorize, for medical purposes, the taking of photographs of my feet.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_