FootWorks
Podiatry & Laser, Inc.

Beatrice A. Schmugler, DPM

**Name**_____ **Age**_____ **Date of Birth**_____

Address_____City_____State_____
Zip_____ Home Phone_____Work_____
Cell_____Email:_____

Patient Employed By _____Occupation_____

**How did you hear about us?** Doctor Internet (Google, Yelp) Friend Other_____

Primary Dr. _____Dr.'s Phone_____ Last Visit_____

Emergency
Contact:_____Phone:_____Relationship_____

Previous Podiatrist ( )No ( ) Yes When_____ Whom_____

Chief Foot Concerns_____

Are you in General Good Health? ( )Yes ( )No If not why?_____

Past Illnesses and/or Operations? _____

Current Medications: _____

Shoe Size:_____ Weight:_____

**If you have had or have any of the following, please check (X)**

| | | |
|---|---|---|
| ( ) Diabetes | ( ) Low Back Pain | ( ) Asthma |
| ( ) Arthritis | ( ) Blood Clot | ( ) Liver Trouble |
| ( ) Heart Trouble | ( ) Tuberculosis | ( ) Anemia |
| ( ) High Blood Pressure | ( ) Blood Disease | ( ) Rheumatic Fever |
| ( ) Bleeding Disorder | ( ) Stroke | ( ) Drug Reaction |
| ( ) Gout | ( ) Eye Trouble | ( ) Other_____ |

If you are allergic or sensitive to any of the following, please check (X) and describe the type of reaction.

( ) Novocaine:_____ ( ) Penicillin:_____ ( ) Sulfa:_____

( ) Adhesive Tape:_____ ( )Latex:_____ ( )Other Drugs:_____

Do you smoke? No Yes -how much? _____ Do you drink Alcohol? No Yes -how much_____

**I understand that honest and complete answers to each question stated above are important to my medical care and I have answered them to the best of my ability. If I am uncertain about any question on the form, I will ask the doctor or a member of the office staff for assistance.**

Date_____ Signature_____

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www.footworkspodiatry.com