

Autoimmune Disease(s)

## D.A. Springer, B.Sc., D.Ch., FRSH Chiropodist/Foot Specialist

## **New Patient Consultation**

Patient name:		DOB:			
Ht	Wt	Shoe size			
Address City/Town Ph. (Home)	Bus.	Pos	Apt. tal Code		
Occupation Employer					
	covered under any additional ty ife, Blue Cross, Aetna, etc.?	pe of medical insurance that covers prescripti	ons, eyeglasses or		
MD Address		Ph.			
How did you hear about	us?				
Name of referring family,	friend/patient/newspaper/Yellov	w Pages/radio/TV/insurance company/employ	ver/other:		
Medications					
No you regularly take: blood thinners? (Aspirin, Coumadin, Vitamin E), Cortisone or other steroids?  Medication/substance allergies:  Latex Tape lodine IVP Dye Shellfish (check all that apply)  lave you ever taken a medication that caused a skin rash, facial swelling, or difficulty breathing, vomiting, nausea, dizziness, iarrhea, or headache? Y / N If yes, please list medication name and reaction:  es No  Have you ever had trouble with spinal, general, or local anesthesia? Y / N If yes, please explain:					
	•	Shellfish (check all that apply)			
diarrhea, or headache?			iting, nausea, dizziness,		
-	ole with spinal, general, or local	anesthesia? Y / N If yes, please explain:			
Family history: mother/fa	ather/brother/sister: diabetes/he	eart disease/cancer/high BP/other:			
Past/current medical hist	ory (check all that apply)				
Diabetes (controlled by:	insulin/pills/diet)	Surgical complications	Heart attack/leaky valve		
Irregular heartbeat/congo	estive heart failure	High BP/stroke	Cancer (type)		
Epilepsy		High cholesterol			
Poor circulation/varicose veins		Osteoarthritis/rheumatoid arthritis Cirrhosis/hepatitis A,B,C	Degenerative joint disease/gout		
Stomach/bowel problems	S	HIV/AIDS	Asthma/bronchitis/COPD bladder/kidney/urinary trouble		
Parkinson's		Alzheimer's	Headaches/depression/anxiety		
Skin trouble/rashes		Leg/foot sores/ulcers	Dentures/glasses		
Thyroid trouble		Joint replacement	Bleeding problems/anemia		
Blood clots		Slow wound healing	Hay fever/allergies		
		Olow Would Healing	Other		



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FOR CLINICIAN US	SE:					
Review of Systems/Other: HEENT			CV		RESP	
GI	GU		RENAL_		ENDO	
NERV	MSK		DERM			
Surgeries / hospitaliza	ations / childbir	th history (list date	es/procedures)	:		
Foot Concern(s):						
Where:	ere: How long?		days	wks	mon	yrs
Pain scale (1-10):	Describ	e pain:				
Aggravated by: Previous foot care:	walking	standing	shoes	physi	cal activity	
Social history						
Occupation						
Current smoker? Y	N					
Alcohol: Y	N	Occasional				
Consent: By my signature, I here assess and recomme	reby give permi nd treatment fo	ission to D. Andre or my foot conditio	w Springer B.S n(s) as deemed	c., D.Ch., ld necessar	FRSH, Chirop y.	podist/Foot Specialist to
Date		Si	gnature	nature		
By my signature, I her information with my m	eby give permi edical caregive	ssion to D. Andre	w Springer B.S nealth and/or m	c., D.Ch., I y foot cond	FRSH, Chirop lition(s) as de	oodist/Foot Specialist to sha emed necessary.
Date			Si	gnature		
Payment Acknowled	_					
There is a fee for exan	nination and tre	atment. You are	responsible for	fees the d	ay of your vis	it.
Date			 Si	gnature		