All-in-One Foot Care Center
24331 El Toro Rd, Suite 370
Laguna Woods, CA 92637
949-588-8833

Medical History Form

1. Patient Information

First Name:

Last Name:

Email:

Address:

City:

State:

Zip Code:

Date of Birth:

Home Phone:

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Minor ◯ Separated ◯ Divorced ◯ Partnered

Sex: ◯ Male ◯ Female

Employer / School:

Employer / School Phone:

In case of emergency contact Name & address:

2. Insurance

Who is the primary on this account: ◯ Self ◯ Other Please specify:

Date of birth of the primary:

Relationship to patient: ◯ Self ◯ Other Please specify:

Insurance Company:

Group Number:

Subscriber ID:

Insurance Phone Number:

Is patient covered by other insurance: ◯ No ◯ Yes

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the above insurance company and assign directly to All-in-One Foot Care Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my acceptance on all insurance submissions. All-in-One Foot Care Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the submission date of this form.

☐ I Agree (Beneficiary, Guardian or Personal Representative)

Name: _____

Relationship to beneficiary: _____

3. Podiatric and Medical History

Main reason for visiting us: e.g. foot, ankle, knee... _____

Have you been to a Podiatrist(s) before: ◯ No ◯ Yes Please list name(s)specify: _____

Cigarette / Tobacco use: ◯ No ◯ Yes Please specify years smoked: _____

Is there any personal or family history of diabetes: ◯ No ◯ Yes

Please indicate which foot problems you now have or have had in the past:

Ankle Pain:	◯ Yes ◯ No	Flat Feet:	◯ Yes ◯ No
Athlete's Foot:	◯ Yes ◯ No	Foot or Leg Cramps:	◯ Yes ◯ No
Bunions:	◯ Yes ◯ No	Heel Pain:	◯ Yes ◯ No
Corns & Calluses:	◯ Yes ◯ No	Ingrown Toenails:	◯ Yes ◯ No
Cramps or Numbness in Feet or Legs:	◯ Yes ◯ No	Plantar Warts:	◯ Yes ◯ No

Please choose "YES" or "NO" to indicate if you have had any of the followings:

AIDS/HIV:	◯ Yes ◯ No	Hepatitis or Jaundice:	◯ Yes ◯ No

Allergies to Anesthetics:	Yes No	High Blood Pressure:	Yes No
Allergies to Medicine or Drugs:	Yes No	Kidney Problems:	Yes No
Anemia:	Yes No	Liver Disease:	Yes No
Angina:	Yes No	Low Blood Pressure:	Yes No
Arthritis:	Yes No	Neuropathy:	Yes No
Artificial Heart Valves or Joints:	Yes No	Phlebitis:	Yes No
Asthma:	Yes No	Psychiatric Care:	Yes No
Back Problems:	Yes No	Radiation Treatment:	Yes No
Bleeding Disorders:	Yes No	Rash:	Yes No
Cancer:	Yes No	Respiratory Disease:	Yes No
Chemical Dependency:	Yes No	Rheumatic Fever:	Yes No
Chest Pain:	Yes No	Shortness of Breath:	Yes No
Chronic Diarrhea:	Yes No	Sinus Problems:	Yes No
Circulatory Problems:	Yes No	Special Diet:	Yes No
Diabetes:	Yes No	Stroke:	Yes No
Ear Problems:	Yes No	Swelling in Ankles, Feet:	Yes No
Epilepsy:	Yes No	Swollen Neck Glands:	Yes No
Eye Problems:	Yes No	Tired Feet:	Yes No
Fainting:	Yes No	Tuberculosis:	Yes No
Gout:	Yes No	Ulcers:	Yes No
Headaches:	Yes No	Varicose Veins:	Yes No
Heart Disease:	Yes No	Venereal Disease:	Yes No
Hemophilia:	Yes No	Weight Loss, Unexplained:	Yes No

Surgeries you have had:

Hospitalization other than for the surgeries listed:

Family physician Name& last date visited:

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ◯ No ◯ Yes
Please explain:

Medications? Include prescriptions, over-the-counter medications and vitamins:

Pharmacy Name(s):

Pharmacy Phone(s):

Do you take oral contraceptives: ◯ No ◯ Yes

Allergies

Adhesive/Tape: ☐
Anticoagulant Therapy: ☐
Aspirin: ☐
Codeine: ☐
Demerol: ☐
Iodine: ☐
Other: ☐ Please explain:

Local Anesthetics: ☐
Novocaine: ☐
Penicillin: ☐
Seafoods: ☐
Sulfa: ☐

Treatment Consent

☐ I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor seems necessary.

By typing your initials in the box you consent that you have reviewed ALL answers: