John M. Hurchik, D.P.M
Sarah M. Montgomery, D.P.M

Patient Information

Date:_____

Name:_____ Date of Birth:_____ Age:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell #:_____

Email:_____@_____

Primary Language:_____Marital Status: S____ M____ W____ D____

Employer:_____ Occupation:_____

Race(optional) Caucasian____ Hispanic____ African-American____ Asian____ Other_____

Name of Husband/Wife/Parent:_____

Primary Care Physician:_____ Phone Number:_____

Whom may we thank for referring you to our office?_____

Medical Information

Describe your foot problem:_____

How long has it been bothering you?_____ Any Prior treatment?_____

Any prior problems with your feet or ankles?_____

What is your pharmacy?_____ Location/Phone_____

What medications do you take?_____

Do you have Diabetes? Yes____No____If yes, do you take insulin? Yes____No____Pills? Yes____No____

How many years ago were you diagnosed with diabetes?_____ Last Hemoglobin A1C?_____

Please Check off any of the following conditions you currently have or have had in the past:

___Anemia ___ Cancer ___ High Blood Pressure ___ Nerve Disorder

___Arthritis ___Circulation ___Intestines ___Skin Condition

___Asthma ___Gout ___Kidneys/Urinary/Bladder ___Stomach Ulcers/AcidReflux

___Bleeding Disorder ___ Heart Disease ___Liver/Hepatitis ___Stroke

Other Medical Conditions? Yes____ No____ If yes, Please Specify:_____

Any Allergies?:_____

Prior Surgeries?_____

_____

Family History

(Please circle one) (Please check off all that apply)

Mother: Alive or Deceased ___Diabetes ___Heart Disease ___High Blood Pressure ___ Cancer

Father: Alive or Deceased ___Diabetes ___Heart Disease ___High Blood Pressure ___ Cancer

Brothers: Alive or Deceased ___Diabetes ___Heart Disease ___High Blood Pressure ___ Cancer

Sisters: Alive or Deceased ___Diabetes ___Heart Disease ___High Blood Pressure ___ Cancer

Do you currently Smoke? Yes___ No___ If Yes, # of years_____ # Cigarettes per day_____

If no, previously smoked? Yes___ No___ If yes, # of years_____

Do you drink alcohol? ___No ___ Light(1-2 drinks/week) ___Moderate(1-2/day) ___Heavy(>2/day)

Shoe Size:_____ Current Weight:_____ Height:_____