ABSOLUTE FOOT CARE
a gentle approach to foot care

Name: _____ Address:_____
DOB :_____ Sex : F / M Telephone: _____ Soc. Sec# :_____
Marital Status: _____ Race:_____ Ethnicity:_____ Language: _____
Email: _____ Primary DR:_____
In case of Emergency: _____ Relation:_____ Tel :_____
Pharmacy:_____ Location:_____ Tel:_____
Primary Insurance:_____ Name:_____ ID: _____
Secondary Insurance:_____ Name:_____ ID: _____

Height: _____ Weight:_____ How much did weight at the age of 18 yrs?_____
Have you had any Surgeries? (*Include year*)_____
_____
Hospitalizations: ☐No ☐Yes Reason:_____
Allergies to any of the following: ☐ Latex ☐ Penicillin ☐ Aspirin ☐Codeine Other:_____
Are you on any of these blood thinners? ☐Coumadin ☐ Pradaxa ☐ Plavix ☐Pletal ☐ Aspirin

Current Medications: (if you have more please list on the back of this form)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

REVIEW OF SYSTEMS (please check if answer is "YES")

☐ Kidney Problems
☐ Liver Problems
☐ Atrial Afib
☐ Difficulty hearing/Deafness
☐ Swollen Joints
☐ Stiff Joints
☐ Blurred Vision
☐ Muscle Aches
☐ Painful Joints
☐ Bipolar Disorder
☐ Schizophrenia
☐ Nausea
☐ Muscle Weakness
☐ Burning
☐ Blood in Stool

☐ High Blood Pressure
☐ Tuberculosis
☐ Palpitations
☐ Depression
☐ Stroke
☐ Glaucoma
☐ Thyroid
☐ Asthma
☐ Epilepsy
☐ Ulcers
☐ Heart Attacks
☐ Blindness
☐ Loss of Appetite
☐ Tingling/Numbness
☐ Pneumonia

☐ Diabetes
☐ Cholesterol
☐ Cancer
☐ Anemia
☐ Arthritis
☐ Hepatitis
☐ Arrhythmia
☐ HIV Positive
☐ AIDS
☐ Anxiety
☐ Bronchitis
☐ Headaches
☐ Productive Cough
☐ Frequency
☐ Urgency

Education Level: ☐Elementary ☐High School ☐University ☐ Post College Degree
Smoke? ☐No ☐Yes___packs/a day ☐Quit _____ Drink? ☐Never ☐Socially ☐Recovering Alcoholic

Do you exercise on a regular basis? ☐No ☐Yes (specify):_____

Shoe Size? 4 5 6 7 8 9 10 11 12 13 14 15 16 ☐ Narrow ☐ Regular ☐ Wide ☐ Extra Wide

Rx History Consent: I hereby authorize Dr. James J. Longobardi, DPM, MBA to obtain my previous prescription/medication history through external sources. _____
(Initials)

I have completed this health history questionnaire truthfully and to the best of my knowledge. I understand if I falsified information I can be held responsible and could be prosecuted as an applicable by local, state and federal laws. I further understand that if I answered any questions untruthfully I may put my health or the health of others at risk.

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Dr. James J. Longobardi,DPM, MBA. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any visit copayment due at time of services and/or deductibles, additional fees for form processing, returned checks, copying of medical records and missed appointments that may apply. If this account is assigned to an attorney for collection and/or suit, a co[y of the signature is valid as the original.

Patient Signature: _____ Date: _____ /_____ /_____