David J. Valvo, DPM, P.C.

WELCOME TO OUR PRACTICE

Last Name_____First Name_____

Address_____City_____State___ ZIP_____

Phone #_____Date of Birth_____ Age_____

Employer_____ Occupation_____ Work #_____

Social Security #_____/_____/_____ Gender_____ Marital Status_____

Primary Insurance_____ Policy #_____

Subscriber_____ Date of Birth_____Relationship_____

2ND Insurance (If applicable)_____Policy #_____

Subscriber_____ Date of Birth_____Relationship_____

Referred By_____ Primary/Family Doctor_____

HEALTH HISTORY

BRIEFLY STATE YOUR FOOT PROBLEM_____

PLEASE CHECK: *Left Foot*___ *Right Foot*___ *Both Feet*___ Duration_____

PLEASE CHECK BELOW IF YOU HAVE EVER HAD OR DO HAVE ANY OF THE FOLLOWING

_____High Blood Pressure	_____Diabetes	_____Heart Disease
_____Bone Problems	_____Asthma	_____Tuberculosis
_____Stomach Disorders	_____Cancer	_____Arthritis
_____Rheumatic Fever	_____Neurologic Disorders	_____Skin Disease
_____Phlebitis	_____Psychiatric Disorders	_____Gout
_____Kidney Disease	_____Eye Disease	_____Epilepsy
_____Liver Disease	_____High Cholesterol	_____Blood Clots

ARE YOU SUBJECT TO PROFUSE BLEEDING? Yes___ No___

ARE YOU CURRENTLY PREGNANT? Yes___ No___ Birth Control Pills? Yes___ No___

ARE YOU UNDER THE CARE OF A PHYSICIAN? Yes___ No___ Purpose? _____

ALLERGIES TO MEDICATIONS_____

LIST ALL SURGERIES_____

LAST VISIT TO FAMILY PHYSICAN_____