

Welcome To Our Office
Dr. Robert G. Rosen, DPM, FACFAS, CWS
Brevard Podiatry
Confidential Patient Information

Date: _____

Acct.: _____

Patient Information:

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

How do you want us to contact you for your appointments: Home / Cell and do you prefer Text / Call (Circle Preferences)

Social Security: _____ Birth Date: _____

Sex: Male / Female

Marital Status: S / M / D / W

Primary Email: _____ Employer & Occupation: _____

Emergency Contact: _____ Relation/Phone: _____

Responsible Party: (Circle Relation to Patient)

Spouse / Parent / Other: _____ Phone: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____ Birth Date: _____

Sex: Male / Female

Primary Email: _____

Current Physicians:

Name of Family Doctor: _____ Date Last Seen: _____

Address: _____ Phone: _____

Name of other doctor: _____ Date Last Seen: _____

Address: _____ Phone: _____

What is the purpose of your visit today?:

What activities are you having problems with due to your condition: (Circle all that apply)

Walking / Running / Exercise / Sleeping / Going Out / Working / Other: _____

Does your condition cause you pain: Yes / No **How Often:** Constant / Occasionally / AM / PM

Please describe your pain: (Circle all that apply)

Stabbing / Shooting / Aching / Throbbing / Sharp / Dull / Stiff / Other: _____

Pain Level – 1 being the lowest 10 being the highest: _____

Medical History: (Circle all that apply)

Anemia	Yes / No	Dizziness	Yes / No	Neuropathy	Yes / No
Arthritis	Yes / No	Fainting/Blackouts	Yes / No	Pregnant	Yes / No
Asthma	Yes / No	Gout	Yes / No	Recent Weight Loss	Yes / No
Back Pain	Yes / No	Headaches	Yes / No	Skin Rashes	Yes / No
Bleeding (Abnormally)	Yes / No	Hearing Problem	Yes / No	Stomach Problem	Yes / No
Cancer (Type)	Yes / No	Heart Problem	Yes / No	Stroke	Yes / No
Cholesterol (High)	Yes / No	Hepatitis A,B,C	Yes / No	Thyroid	Yes / No
Circulation Problem	Yes / No	HIV / Aids	Yes / No	Tuberculosis	Yes / No
Colitis/IBS	Yes / No	High Blood Pressure	Yes / No	Vision Problem	Yes / No
COPD/Emphysema	Yes / No	Intestinal Ulcers	Yes / No	Other	
Convulsions/Seizures	Yes / No	Kidney Problem	Yes / No	Other	
Depression/Anxiety	Yes / No	Liver Problem	Yes / No	Other	
Diabetes (Type)	Yes / No	Lyme Disease	Yes / No	Other	

Shoe Size: _____ **Height:** _____ **Weight:** _____

Current Medications: (Please Provide List If Available)

Allergies to Medications/Foods etc.:

Social History:

Do you smoke Tobacco: Yes / No Frequency _____ Packs (Per) _____ Day _____ Week _____ Month

Do you drink Alcohol: Yes / No Frequency _____ Drinks (Per) _____ Day _____ Week _____ Month

Do you use Recreational Drugs: Yes / No Type: _____

Surgical History: (Please Provide List If Available)

Procedure

Family History:

Grandparent Father Mother Siblings Children Spouse

Arthritis _____
 Cancer _____
 Diabetes _____
 Heart Disease _____
 High Blood Press. _____
 Kidney Disease _____
 Other _____

How Did You Learn About Our Office: (Please Complete All That Applies)

Doctor Referral: _____ Family Friend: _____

Insurance Co.: _____ Other: _____

By signing this medical statement, you agree that all the information to be true to your knowledge and no false information was given.

Print Patient Name

Patient or Guardian Signature

Date