Welcome To Our Office
Dr. Robert G. Rosen, DPM, FACFAS

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**

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