

**Martin J. Faasse, D.P.M., P.C.**

Medical and Surgical Foot Specialist

Diplomate, American Board of Podiatric Surgery

Board Certified in Foot Surgery

**History and Registration Form:** Please fill out and bring to your first visit.

Patient's Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex:  Male  Female

Guardian's Name (If patient is a minor): \_\_\_\_\_

Guardian's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Primary Insurance (choose one):  Medicare  Medicaid  BCBS  Priority Health  
 PPOM  United Healthcare  Blue Care Network  Other: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Birth Date of Policy Holder: \_\_\_\_\_

Policy/Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

What is your foot problem? \_\_\_\_\_

When did this problem start? \_\_\_\_\_

Have you treated this problem at home?  Yes  No If yes, how? \_\_\_\_\_

Have you had foot treatment before?  Yes  No If yes, by whom? \_\_\_\_\_

Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Are you in:  Good health  Fair Health  Poor Health

Are you subject to prolonged bleeding and/or healing difficulties?  Yes  No

Family Physician: \_\_\_\_\_

Please complete second page.

**Martin J. Faasse, D.P.M., P.C.**

Medical and Surgical Foot Specialist

Diplomate, American Board of Podiatric Surgery

Board Certified in Foot Surgery

Are you under the care of a doctor now?  Yes  No If yes, why? \_\_\_\_\_

Which doctor is currently caring for you? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many per day? \_\_\_\_\_

Are you pregnant?  Yes  No If yes, when is your due date? \_\_\_\_\_

What medications are you currently taking? 1. \_\_\_\_\_

2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_

**I am allergic to:**

Antihistamines

Novocain

Tape adhesives

Aspirin

Nylon/Plastics

Other:

Codeine

Penicillin

\_\_\_\_\_

Demerol

Sulfa

\_\_\_\_\_

Iodine

Sutures

\_\_\_\_\_

**I am not allergic to anything to my knowledge.**

**I have or have had the following:**

Diabetes

Back Problems

Hip Problems

Knee Problems

Arthritis

Leg Cramps

Varicose Veins

Circulation Problems

Phlebitis

Anemia

Kidney Disease

Bleeding Tendencies (Blood Clots)

Gout

Cancer

Hypertension

Difficulty Swallowing

CVA

Stroke

Heart Trouble

Asthma

If you are not diabetic, are you aware of any family member who had or has it?  Yes  No

If yes, what relation to you? \_\_\_\_\_

Past surgeries and hospitalizations: \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature (If patient is a minor): \_\_\_\_\_