Howard Burkett, DPM
Family Foot Health
Foot and Ankle Specialist

PATIENT INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP: _____

DRIVER'S LICENSE NUMBER: _____ TELEPHONE # _____

CELL PHONE # _____

EMPLOYER: _____ PHONE # _____ OCCUPATION _____

EMPLOYER ADDRESS: _____ CITY: _____ ZIP: _____

NAME OF INSURANCE PLAN: _____ I.D. # _____

MARITAL STATUS: MARRIED DIVORCED SINGLE

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT NAME: _____ PHONE # _____

RESPONSIBLE PARTY IF A MINOR: _____ PHONE # _____

HOW DID YOU HEAR ABOUT US: PHONE BOOK SIGN WEB SITE

PATIENT REFERRAL PHYSICIAN REFERRAL OTHER

FAMILY PHYSICIAN: _____ PHONE # _____

PHARMACY: _____ PHONE# _____

PERSON FINANCIALLY RESPONSIBILE FOR THIS ACCOUNT: _____

PLEASE PRESENT YOUR CURRENT INSURANCE IDENTIFICATION CARD AND I.D. SO WE MAY COPY THEM FOR VERIFICATION OF COVERAGE

Brookwood Manor | 13 Brookwood Ave, | Suite One | Carlisle, PA 17013 | (717) 249-9505

Board Certified: American Board of Podiatric Surgery | Diplomate American Board of Podiatric Surgery | American College of Foot and Ankle Surgeons

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Name_____Date_____

What foot/ankle problems are you having?

_____

_____

_____

Where?_____For how long?_____

Any previous treatment?_____

Height_____Weight_____Shoe Size_____

Past Medical History-please circle any current or prior conditions (even if years ago)

cancer (specify)_____	back pain, hip/knee pain	asthma
high blood pressure	fractures (specify)_____	emphysema
high cholesterol	arthritis	pulmonary embolus
heart attack	sprained ankle/foot	HIV
stroke	rheumatoid arthritis	hepatitis
blood clots	fibromyalgia	rheumatic fever
poor circulation	neuromuscular disease	cellulitis or gangrene
leg/foot swelling	frequent urinary infections	blood poisoning
congestive heart failure	kidney disease or dialysis	polio
leg/foot numbness	hernia	depression
burning or tingling	heartburn/reflux	anxiety
sciatica	stomach ulcer	bipolar disorder
weakness	jaundice	developmental abnormality
seizures	pancreatitis	(specify)_____

Other Conditions_____

Past Surgical History- please list all surgeries you have EVER had, not just foot-related, as well as the approximate date performed

_____

_____

_____

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Tobacco Use- Yes/No Past or current packs/day_____ Quit? How long ago_____

Alcohol Consumption- Yes/No # drinks_____per day/week/month (circle frequency)

Illicit drug use current or past_____

Family Medical History- list any history of foot problems or any major medical problems in your close relatives

_____

_____

Medications- list all medications, supplements, herbals, and vitamins you use, as well as what you take them for (if too many please provide a list copy)

1)_____for_____ 7)_____for_____

2)_____for_____ 8)_____for_____

3)_____for_____ 9)_____for_____

4)_____for_____ 10)_____for_____

5)_____for_____ 11)_____for_____

6)_____for_____ 12)_____for_____

What pharmacy do you use?_____Phone#_____

Allergies- list all allergies to medicines, chemicals, metals, latex, or foods, as well as what happens when you are exposed to these products

_____

_____

_____

Body System Review- list any other abnormal symptoms in your head, neck, chest, stomach/bowel, genitalia, urinary tract, joints/bones/muscles, nerves, or any other symptoms you can describe

_____

_____

_____

Please tell us who your primary care physician or family doctor is_____

Any other physcians involved in your care? Please list them here, along with their specialty_____

_____

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