CAPITAL FOOT CARE, PC
JAMES E. SHADBOLT, DPM

WELCOME TO OUR OFFICE!

PLEASE PRINT

Patient's Name_____ Sex_____
(First) (Middle) (Last)

Street Address_____City_____

State _____ Zip Code _____ Home Phone _____Cell#_____

Social Security # _____ Date of Birth _____/_____/_____ Age _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Weight_____ Height_____ Shoe Size_____ Shoe Width_____

Occupation_____ Employer _____

Employer Address_____City_____

State_____ Zip Code _____ Work Phone _____Ext_____

Responsible Party or Parent (If patient is a minor)_____
(First) (Middle) (Last)

Street Address _____ City_____

State_____ Zip Code _____ Home Phone_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Primary Insurance_____ Policy #_____

Group # _____ **Subscriber** _____ **Relationship** _____

Subscribers Social Security #_____**Date of Birth**_____

Secondary Insurance _____ Policy # _____

Group # _____ Subscriber _____ Relationship _____

Subscribers Social Security # _____Date of Birth_____

Race:
__ American Indian/Alaska ___ Asian ___Black/African American ___White
___ Native Hawaiian/Pacific Islander ___ Refuse to Report

Ethnicity:
___ Hispanic/Latino ___Non-Hispanic/ Non-Latino ___ Refuse to Report

Primary Language:
___ English ___ French ___German ___ Japanese ___ Mandarin ___ Russian ___ Spanish

Tobacco History:
___ Current Smoker
___ Occasional Smoker
___ Former Smoker
___ Non-Smoker

PHARMACY NAME: _____ PHARMACY Phone#:_____

Pharmacy Address/ CROSS STREETS: _____

What is your present complaint with your feet? _____

_____

How long have these symptoms been present? _____

Have you received any treatment for this condition? ____Yes_____No If "yes" by whom? _____

Primary Care Doctor _____ Phone #_____

Other Doctor _____ Phone #_____

Previous Podiatrist _____ Phone #_____

PLEASE LIST ALL MEDICATIONS & VITAMINS: _____

_____

Are you Allergic to: ☐ **NO KNOWN ALLERGIES**

☐ Penicillin ☐ Iodine ☐ Aspirin ☐ Bee Stings

☐ Sulfa ☐ Codeine ☐ Latex ☐ Other

☐ Novocaine ☐ Demerol ☐ Adhesive Tape _____

Check all that apply: ☐ **No Known Medical Problems**

☐ Diabetes ☐ Scarlet Fever ☐ Liver Condition ☐ Stroke

☐ Polio ☐ Venereal Disease ☐ High Blood Pressure ☐ Low Sugar

☐ Asthma/Bronchitis ☐ Hepatitis A/B/C ☐ Low Blood Pressure ☐ Tumor

☐ Anemia ☐ Epilepsy ☐ Prolonged Bleeding ☐ Gout

☐ Tuberculosis ☐ Slow Healing ☐ Arthritis ☐ Phlebitis

☐ Ulcers/Stomach ☐ Ulcers/Intestines ☐ Kidney Condition ☐ Rheumatic Fever

☐ Vascular Disease ☐ Exposure to HIV ☐ Blood Transfusion ☐ Rheumatoid Arthritis

☐ Knee Replacement ☐ Hip Replacement ☐ Other _____

_____

Heart Disease (Please describe):_____

_____

List all Previous Surgery (Date and Type):_____

_____

_____