

**Lighthouse Family Foot and Ankle Center, PC**  
**Dr. Michele N. Kurlanski, DPM**

**PATIENT INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

May we contact you by e-mail (address) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex:    \_\_\_ Female   \_\_\_ Male   \_\_\_ Married   \_\_\_ Single   \_\_\_ Widowed   \_\_\_ Divorced

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT \_\_\_\_\_

**INSURANCE INFORMATION/WORKER'S COMP.**

Employer: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Group # \_\_\_\_\_ Member ID# \_\_\_\_\_

Is Patient covered by additional insurance?       \_\_\_ Yes   \_\_\_ No

Insurance Co. Name: \_\_\_\_\_

Group # \_\_\_\_\_ Member ID# \_\_\_\_\_

Worker's Comp Claim Number \_\_\_\_\_

Date of Injury \_\_\_\_\_

**PODIATRIC HISTORY**

What is the main complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.) \_\_\_\_\_

---

How long have you had the problem? \_\_\_\_\_

What has been done to treat the problem? \_\_\_\_\_

Have you ever been to a Podiatrist before?   \_\_\_ Yes   \_\_\_ No

Is your problem related to an accident, job, sports, or trauma etc?   \_\_\_ Yes   \_\_\_ No

**MEDICAL HISTORY**

Are you allergic to medication? \_\_\_\_\_ Which medication? \_\_\_\_\_

Please list any medications and dosages that you are taking: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

- |             |  |                     |  |
|-------------|--|---------------------|--|
| Diabetes    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart trouble       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hyperthyroidism     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reflux disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clots | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |  |
| Pregnant    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                     |  |

Past surgical history: \_\_\_\_\_

**FAMILY HISTORY:**

Have any family members had:

- |           |  |                     |  |
|-----------|--|---------------------|--|
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart trouble       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hyperthyroidism     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gout      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**SOCIAL HISTORY**

Cigarette/Tobacco us \_\_\_\_\_ Yes (\_\_\_\_\_ yrs smoked) \_\_\_\_\_ No

Alcohol Use \_\_\_\_\_ daily \_\_\_\_\_ social \_\_\_\_\_ never

Exercise activity \_\_\_\_\_

Occupation/work history \_\_\_\_\_

**Review of Systems:** Do you have any of the following problems:

- |                         |  |                     |  |
|-------------------------|--|---------------------|--|
| Recent weight loss/gain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vision problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty swallowing   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty breathing    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral valve prolapse   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low back pain       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bowel problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood clots         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty healing      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety/depression  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting/seizures       | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV positive        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Joint replacement       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Review of Systems Continued:**

Please indicate which foot problems you now have or have had in the past:

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corns/Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps/Numbness in feet or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Swelling in ankles or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No		

I hereby give my permission to have my feet and ankles examined and treated, only if necessary, by Dr. Michele Kurlanski. I understand and agree that regardless of my insurance coverage and/or status I am responsible for the balance on my account for any professional services rendered. I will notify the doctor of any changes in my health status or any of the above information, which is true to the best of my knowledge. I authorize use of this form on all insurance submissions. This form may be used as a release of information. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company and authorize payment directly to my doctor. A copy of this form is as valid as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_