OCALA
PODIATRY

DR. ANDREW FRANKLIN DPM, PhD

Date: _____

Patient Name: _____

DOB: _____ SS#: _____

Gender: Male Female

Home Address: _____ City: _____

State: _____ Zip Code: _____

Phone number: _____ Email: _____

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or other pacific islander
- ☐ White
- ☐ Unknown
- ☐ Decline to answer

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to answer

Emergency Contact:

Name: _____

Contact Phone #: _____

Relation to Patient: _____

Name: _____

Height: _____ Weight: _____

Primary Care Physician: _____ Date last seen: _____

Pharmacy: _____

Pharmacy Address: _____ Tel: _____

Have you seen Dr Franklin in the past? Yes No If yes when? _____

Medical History:

Diabetes:

- ☐ Type 1
- ☐ Type 2
- ☐ Insulin Dependent
- ☐ Oral medication
- ☐ Diet controlled

Please check all those that apply:

- ☐ Anemia
- ☐ BPH
- ☐ CHF
- ☐ Dementia
- ☐ Epilepsy
- ☐ HIV
- ☐ MI
- ☐ Stroke
- ☐ Anxiety
- ☐ Back problems
- ☐ COPD
- ☐ Depression
- ☐ GERD
- ☐ Headaches
- ☐ Migraines
- ☐ TB
- ☐ Arthritis
- ☐ Breast Ca
- ☐ Cancer
- ☐ Dermatitis
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ CAD
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Gout
- ☐ Hypertension
- ☐ Renal Stones
- ☐ Ulcer (GI)

Other: _____

Medications:

Please list all medications you are taking:

_____

_____

_____

_____

_____

Allergies:
Please check all those that apply:

- ☐ Codeine
- ☐ Egg Derived
- ☐ Fish products
- ☐ Gluten
- ☐ Influenza Vaccine
- ☐ Lactose
- ☐ Latex
- ☐ NSAIDs
- ☐ Peanut
- ☐ Penicillins
- ☐ Shellfish
- ☐ Sulfa

Other: _____

Social History:

Smoking history

Cigarette/tobacco: Yes No

- ☐ Current smoker
- ☐ Type _____
- ☐ PPD: _____
- ☐ Former smoker
- ☐ Quit Date: _____

Alcohol: Yes No

- ☐ Beer
- ☐ Amount _____
- ☐ Wine
- ☐ Amount _____
- ☐ Liquor
- ☐ Amount_____

Recreational Drugs:

Do you take any recreational drugs?: Yes No

If so, what?: _____ How Often?: _____

Family Medical History:

Mother Living: ___ Mother Deceased: _____ Cause of Death:_____ Age: _____

Any significant medical history (e.g. Diabetes, Cancer etc.)?: _____

Father Living: ___ Father Deceased:____ Cause of Death:_____ Age: _____

Any significant medical history (e.g. Diabetes, Cancer etc.)?: _____

Immunization History

- ☐ Influenza. Date: _____
- ☐ Pneumonia. Date: _____
- ☐ Tetanus. Date: _____

Prior Surgeries

Please check all those that apply:

- ☐ Angioplasty (PVD)
- ☐ Aortic Aneurysm
- ☐ Appendectomy
- ☐ Breast Augment
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Cataract Extraction
- ☐ Cesarean Section
- ☐ Colectomy
- ☐ Duodenal Ulcer
- ☐ Fracture
- ☐ Gallbladder
- ☐ Gastric Banding
- ☐ Heart Valve
- ☐ Hernia
- ☐ Hip Fracture
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Lasik
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Prostate Surgery
- ☐ Shoulder Arthroscopy
- ☐ Shoulder Surgery
- ☐ Sinusectomy (Nasal)
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Vein surgery

Other:_____

Podiatric History:

Please check all those that apply:

- ☐ Amputation
- ☐ Biopsy
- ☐ Bone Spur Removal
- ☐ Bunion Correction
- ☐ Foot/Ankle Fracture
- ☐ Hammer Toe
- ☐ Heel Spur Removal
- ☐ Toenail Surgery
- ☐ Neuroma Removal
- ☐ Tendon Surgery
- ☐ Plantar Fascial Release
- ☐ Wart Procedure

Consent

I certify that the above information is correct to the best of my knowledge, I give permission to Dr. Andrew Franklin to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: _____ Date: _____