# ROBERT ZIMMER DPM
# SEAN NAGLE DPM

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**PLEASE COMPLETE ALL 4 PAGES**

FIRST NAME_____M.I.____ LAST NAME_____

HOME ADDRESS_____CITY/STATE_____ZIP _____

HOME PHONE#_____ALTERNATE PHONE#_____

SOCIAL SECURITY #_____/___/_____ DATE OF BIRTH M_____D_____Y_____ AGE___

GENDER: MALE / FEMALE

MARITAL STATUS: _____

EMERGENCY CONTACT NAME AND PHONE#

_____

**PRIMARY PHYSICIAN**_____

**PHARMACY THAT YOU USE AND LOCATION**_____

LEGAL GUARDIAN OR HEATHCARE POWER OF ATTORNEY

NAME_____RELATION_____PHONE#_____

ADDRESS_____CITY/STATE_____ZIP_____

SOCIAL SECURITY# _____/____/_____ DATE OF BIRTH M_____D_____Y_____AGE___

**EMPLOYER INFORMATION**

EMPLOYER_____PHONE#_____

ADDRESS_____CITY/STATE_____ZIP_____

**PLEASE BRING YOUR INSURANCE CARD WITH YOU SO WE CAN MAKE A COPY**

PATIENT NAME_____ DATE OF BIRTH_____

Who referred you to this office?_____

REASON FOR YOUR VISIT?(Please be specific)

_____

How long ago did this problem start?_____

How would you describe your pain?(please Circle)
No Pain Sharp Pain Dull Pain Aching Burning Radiating Itching Stabbing

On a scale from 1-10 rate your pain (1 no pain - 10 extreme pain)_____

Since the pain began has it: Stayed the same Gotten Worse Improved ?

What makes the pain worse?_____

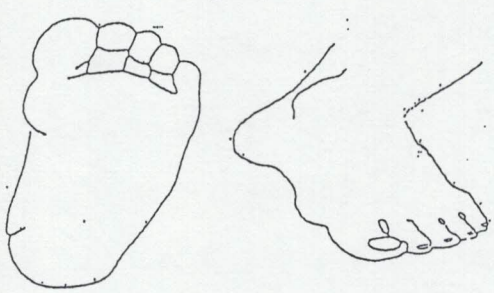
What makes the pain better?_____

How has this affected your lifestyle?_____

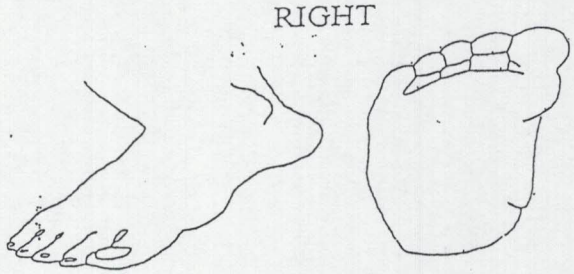
Was this caused by an injury?_____

Where is the pain located? Please mark the pictures below.

LEFT



RIGHT



Patient name_____ Date of birth_____

**REVIEW OF SYSTEMS:** Circle the following symptoms if you have experienced any of them recently.

**Constitutional:** Fever Chills Malaise loss/gain of weight fatigue

**Vascular:** Pain in muscles when walking leg pain at rest cold feet varicose veins

**Gastrointestinal:** Reflux/heart burn Ulcer Abdominal Pain Nausea Diarrhea Vomiting Constipation Rectal bleeding

**Musculoskeletal:** Joint pain Joint stiffness Back/knee/hip pain Joint swelling

**Skin:** Bruising Rash Hives Nodules or bumps Dryness Cracking of skin Color changes with cold

**Neurological:** Numbness Tingling Balance problems Muscle weakness Headaches Dizziness Fainting Confusion

**Endocrine:** Excessive thirst Excessive hunger Frequent Urination Intolerance to heat or cold

**Hematological/Lymphatic:** Anemia Easy bruising Excessive bleeding

**Cardiovascular:** Chest pains Shortness of breath Fainting

**MEDICAL HISTORY:**(Circle all that apply to you).

| | | | |
|---|---|---|---|
| Diabetes | Rheumatoid arthritis | Gouty arthritis | Osteoarthritis |
| Stroke | High cholesterol | High blood pressure | Hypothyroid |
| Asthma | Kidney problems | Liver problems(Hepatitis) | Heart attack |
| COPD | Mental illness | Cancer(what type)_____ | |

Other_____

PAST surgical history(Please list any procedures you have had)

_____

_____

_____

Describe any problems with Anesthesia_____

**WHAT WAS YOUR LAST BLOOD PRESSURE READING?**(If known)_____/_____

**HEIGHT**_____ **WEIGHT**_____

Patient name_____ Date of birth_____

**Social History:**

Smoking History: ____Never smoker.
____Current smoker Packs/day_____ How long?_____
____Former smoker Quit how long ago? _____

Alcohol: NO YES(How many drinks per day)___ How many years____

Recreational Drugs(i.e. Cocaine marijuana)_____

Marital status: Single Married Divorced Widowed
Living situation: Alone Live with others

**Family History:**
Father: Alive? Deceased? What was the cause?_____
Mother: Alive? Deceased? What was the cause?_____
Siblings: Alive? Deceased? What was the cause?_____

Do you have a family history of: Diabetes Heart Disease Cancer(What type)___

**Allergies:**(Please list any medication Allergy you have)
_____
_____

**Medications**(Please list all current medications including dose):
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

To the best of my knowledge I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the Doctor and staff of any changes in my medical status. I authorize Robert A. Zimmer DPM PC to apply for benefits on my behalf for covered services. I request payments from my insurance company be paid directly to Dr. Robert A. Zimmer DPM PC.

Print Patient Name_____

Signature_____ Date_____