Jose A. De Borja, DPM
Podiatrist
Board Certified in Foot Surgery

Chesapeake Family Foot Care, PA

611 Dutchman's Lane
Easton, MD 21601
Phone: 410-822-0991
Fax: 410-822-0577

PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City _____ **State** _____ **Zip** _____

Sex: ☐**M** ☐**F** **Age:** ____ **Birthdate:** _____/_____/_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Patient SS#: _____-____-_____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birth Date: ____/____/____ **Telephone #:** _____-_____-_____

Occupation: _____

Spouses Employer: _____

Whom may we thank for referring you? ☐ **Your Doctor** ☐ **Google** ☐**Phone Book** ☐**Other**

Home Phone: _____ **Emergency Contact:** _____

Cell Phone: _____ **Phone Number:** _____

Work Phone: _____ **Relation:** _____

Email: _____

PODIATRIC HISTORY

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

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No
If yes, please list: Name: _____ **Last Visit**: _____
Is there any personal or family history of diabetes? ☐ Yes ☐ No
Your occupation: _____
Cigarette/Tobacco use _____
Years smoked ____
Athletic activities in which you participate:

_____

_____

_____

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

Ankle pain ☐Yes ☐No
Athlete's Foot ☐Yes ☐No
Bunions ☐Yes ☐No
Corns and Callouses ☐Yes ☐No
Flat Feet ☐Yes ☐No
Foot or Leg Cramps ☐Yes ☐No
Heel Pain ☐Yes ☐No
Ingrown Toenails ☐Yes ☐No
Plantar's Warts ☐Yes ☐No
Swelling in Ankles or Feet ☐Yes ☐No

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MEDICAL HISTORY

Place a check mark to indicate if you have or have had any of the following:

AIDS/HIV ___
Allergies to Anesthetics___
Allergies to Medicine/Drugs ___
Anemia___
Angina___
Arthritis___
Artificial Heart Valves or Joints___
Asthma___
Back Problems___
Bleeding Disorders___
Cancer___
Chemical Dependency___
Chest Pain___
Chronic Diarrhea___
Circulatory Problems___
Diabetes___
Ear Problems___
Epilepsy___
Eye Problems___
Fainting___
Foot or Leg Cramps___
Gout___
Headaches___
Heart Disease___
Hemophilia___
Hepatitis or Jaundice___
High Blood Pressure___
Kidney Problems___
Liver Disease___
Low Blood Pressure___
Nervous Problems___
Psychiatric Care___
Radiation Treatment___
Rash___
Respiratory Disease___
Rheumatic Fever___
Shortness of Breath___
Sinus Problems___
***Special Diet*___**
Stroke___
Swelling in Ankles or Feet___
Swollen Neck___
Glands___
Tired Feet___
Tuberculosis___
Ulcers___
Varicose Veins___

Previous Surgeries _____
Hospitalization other than for the surgeries listed _____
Family Physician _____ **Last Visit**: __/__/____
Are you now, or have you been under any other doctor's care for any reason over the past two years? ☐Yes ☐No
If yes, please explain: _____

MEDICATIONS

Include prescriptions, over the counter medications and vitamins, with dosage amount and frequency:

_____
_____
_____
_____
_____
_____

Pharmacy Name: _____
Pharmacy Phone Number: _____

ALLERGIES

☐**Adhesive/Tape** ☐**Local Anesthetics**
☐**Sulfa** ☐**Novocain**
☐**Aspirin** ☐**Penicillin**
☐**Codeine** ☐**Seafoods**
☐**Demerol** ☐ **Anticoagulant Therapy**
☐**Iodine**
☐**Other: _____**

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

Patients Signature: _____**Date**: _____