

**Fox Valley Foot Specialist**

**Brendon J. McCarthy, D.P.M.**

**1. PATIENT IDENTIFICATION AND CONTACT INFORMATION**

First Name:		MI:	Last Name:		Preferred Nickname	
Address:					City / Zip	
Social Security No.		Sex: M / F	Date of Birth: / /		Shoe Size:	
Married   Single   Divorced			Weight:		Employer:	
Phone Numbers:				Emergency Contact:		
Home: (    ) _____				Name: _____		
Work: (    ) _____				Work #: (    ) _____ - _____		
Cell: (    ) _____				Evening #/Cell: (    ) _____ - _____		
Preferred Pharmacy:						
Name: _____			Street: _____			
City: _____			Phone: (    ) _____ - _____			

**2. REFERRAL SOURCE**

How did you hear about us? _____ Yellow Pages    _____ MD Referral    _____ Passing By    _____ Insurance    _____ Brochure Other: _____
--

**3. PATIENTS DOCTORS**

Physicians name:	Phone Number:	City:	Referred me:
Primary Physician: _____			Y / N
Specialist: _____			Y / N

**4. PATIENT MEDICAL HISTORY**

# Of Childbirths: _____	Are you currently pregnant?    Y / N
Are you slow to heal after cuts?    Y / N	Any abnormal bruising/scarring?    Y / N
Do you smoke?    Y / N    Number of packs a day? _____    Number of years _____	
Did you ever smoke?    Y / N    Number of packs a day? _____    Number of years? _____	
If you quit, when did you do so? _____	
Alcoholic Beverages?    None    Rarely    Moderately    Daily    Quit	