

## MEDICAL QUESTIONNAIRE

Who is your primary care physician? \_\_\_\_\_

What is your present foot problem? \_\_\_\_\_

Please answer each question by circling the appropriate response:

Are you in good health? Yes No

Are you now or have you been under the care of a physician within the past two years? Yes No

Are you subject to nervous disorders or fainting? Yes No

Are you subject to prolonged bleeding after cuts? Yes No

Have you ever experienced ill effects from **NOVACAIN, PENICILLIN,** or other drugs? Yes No

If so, please specify \_\_\_\_\_

Have you ever had any allergies? Yes No

If so, please specify \_\_\_\_\_

Are you currently taking any medication? Yes No

If so, please specify \_\_\_\_\_

\_\_\_\_\_ Yes No

Do you have any abnormal bruising or scarring? Yes No

Have you ever been treated for any of the following:

Diabetes	Y	N	Rheumatic Fever	Y	N
Heart Trouble	Y	N	Tuberculosis	Y	N
Asthma	Y	N	Kidney Ailment	Y	N
High Blood Pressure	Y	N	Gout	Y	N
Stomach Ulcer	Y	N	Liver Ailment	Y	N
Vascular Disease	Y	N	Poor Circulation	Y	N
Arthritis	Y	N	Cancer	Y	N
Osteoporosis	Y	N	Hepatitis	Y	N

Percent of time spent on feet (standing/walking)? 20% 40% 60% 80% 100%

Did you previously or do you now wear shoe inserts or orthotics? Yes No

What is your present foot size? \_\_\_\_\_

Have you had any injuries or operations on your feet and/or legs? Yes No

If so, please specify \_\_\_\_\_

\_\_\_\_\_

Is there any other information about your health that you feel we should know?

\_\_\_\_\_

Is this visit work related? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Is this a result of an auto accident? \_\_\_\_\_

If so, who is your attorney? \_\_\_\_\_

- I authorize Dr. Gregory McNamara to administer treatment or perform any minor operative procedures as may be necessary in the diagnosis and/or treatment of my foot problem.
- I authorize Dr. McNamara to release any information acquired in the course of my examination or treatment only for the purpose of filing medical insurance claims. I also authorize insurance payment directly to Dr. McNamara for the surgical and/or medical benefits that may be payable to me for these services.
- I understand that I **MAY** be responsible for any charges not covered through my insurance policy.

**I understand that:**

1. There will be a minimum fee of \$10.00 for each disability and/or insurance form completed by the office.
2. Copies of x-rays may be obtained for a minimal fee with 48 hours notice (originals cannot be released unless with the Doctor's permission).
3. Copies of patient's records are released only with Doctor's approval.
4. If I do not have medical insurance, I will be expected to sign a statement stating that charges are my total responsibility.
5. All co-payments are to be paid on the day of the visit. If co-payments are not paid on the day of the visit, **I WILL** be responsible for a \$10.00 billing fee in addition to the copay amount.

Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

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