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Saginaw, MI 48603



612 N. Euclid  
Bay City, MI 48706

Andrew H. Cohen, D.P.M.

**Welcome to Our Office**  
**Patient History**  
(Please Print)

Patient's Name \_\_\_\_\_ /Spouse \_\_\_\_\_

Social Security No. \_\_\_\_\_ /Spouse SS# \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse Occupation \_\_\_\_\_ Spouse Employer \_\_\_\_\_

Guardian's Name (if patient is a minor) \_\_\_\_\_

Address (if different than parent's) \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Referred by \_\_\_\_\_

Insured by \_\_\_\_\_

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

When did this problem start? \_\_\_\_\_

Have you had foot treatment before? \_\_\_\_\_ If yes, by whom? \_\_\_\_\_

What was the treatment? \_\_\_\_\_  
\_\_\_\_\_

How have you treated this problem at home? \_\_\_\_\_

Have you injured your feet before, and if so, how? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Please answer the following questions to the best of your ability:

Your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

(Over Please)

Are you in: ( ) good health ( ) fair health ( ) poor health

Are you subject to prolonged bleeding or healing difficulties? \_\_\_\_\_

Do you bruise easily? \_\_\_\_\_ Do you have low back pain? \_\_\_\_\_

Are you under the care of a doctor? ( ) Yes ( ) No If yes, state the reason: \_\_\_\_\_

\_\_\_\_\_

Physician's name and address \_\_\_\_\_

Are you on a diet? \_\_\_\_\_

What medications are you now taking? \_\_\_\_\_

\_\_\_\_\_

Are you pregnant? ( ) Yes ( ) No

Do you: smoke (amount) \_\_\_\_\_ drink alcohol (amount) \_\_\_\_\_

( ) I am not allergic to anything to my knowledge

( ) I am allergic to (Please check)

- |                  |                       |                   |
|------------------|-----------------------|-------------------|
| _____ Aspirin    | _____ Mercurials      | _____ Sutures     |
| _____ Novocaine  | _____ Merthiolate     | _____ Other _____ |
| _____ Codeine    | _____ Iodine          | _____             |
| _____ Demerol    | _____ Adhesives/Tape  | _____             |
| _____ Penicillin | _____ Nylon, Plastics | _____             |
| _____ Sulfa      | _____ Antihistamines  | _____             |

Please check appropriate places. I have, or have had the following:

- |                           |                            |                           |
|---------------------------|----------------------------|---------------------------|
| _____ Diabetes            | _____ Asthma               | _____ Anemia              |
| _____ Bleeding tendencies | _____ Cancer               | _____ Tumors              |
| _____ Epilepsy            | _____ Glaucoma             | _____ Gout                |
| _____ Heart trouble       | _____ Kidney trouble       | _____ High blood pressure |
| _____ Nervousness         | _____ Rheumatism/Arthritis | _____ Stomach ulcers      |
| _____ Stroke              | _____ Tuberculosis         | _____ Polio               |
| _____ Varicose Veins      | _____ Leg Cramps           | _____ Arteriosclerosis    |

If you have not had diabetes, are you aware of any family member who has had it? \_\_\_\_\_ If so, who? \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_

I hereby give permission to Dr. Andrew H. Cohen to treat my foot condition.

Date \_\_\_\_\_ Signature of patient \_\_\_\_\_

Parent or guardian (if patient is a minor) \_\_\_\_\_