Limons
Foot & Ankle Care

Welcome To Our Office

4614 26th St., West
Bradenton, FL 34207
Tel.: (941)756-6906
Fax: (941)751-0976

2677 S. Tamiami Trail, Ste. S
Sarasota, FL 34239
Tel.: (941)955-FOOT (3668)

Patient Account Number: _____

Name of patient: _____ (Circle One) Mr. Mrs. Ms. Miss. Dr.
Last First Middle Initial

Marital Status: (Circle One) Married Single Widowed Divorced Date of Birth: _____

Race: _____ Ethnicity: _____ Patients E-mail: _____

Social Security: _____ Home Phone: _____ Cell Phone: _____

Primary Address: _____
Street Address City State Zip

Secondary Address: _____
Street Address City State Zip

Which address is listed with your Insurance? (Circle One)Primary Secondary

Referred by: _____ Primary Care: _____ Phone: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Date of Last Menstrual Cycle (Females Only): _____ Pregnant? Yes No

Employment: (Circle One) Full Time Part Time Unemployed Retired Employers Name: _____

Employers Address: _____ Work Phone: _____

Student: (Circle One) Full Time Part Time Schools Name: _____ Grade: _____

Name of Husband, Wife, Parent or Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Insurance: _____ Subscriber (Insured) Name: _____

Subscriber Social Security: _____ Date of Birth: _____ Employer: _____

Patients Relationship to Insured: (Circle One) Self Spouse Significant Other Child

Secondary Insurance: _____ Subscriber (Insured) Name: _____

Subscriber Social Security: _____ Date of Birth: _____ Employer: _____

Patients Relationship to Insured: (Circle One) Self Spouse Significant Other Child

Patients Signature: _____ Date: _____

LIMONS FOOT & ANKLE CARE

Patient Name: _____ Birth date: _____ Account Number: _____

Reason for visit: _____

_____ Date of onset _____

Former Podiatrist: _____ Date last seen: _____

Medical History (check only those items that apply)

- ❑ Diabetes diet/oral/insulin ___yr
- ❑ Kidney disease
- ❑ Anemia
- ❑ Peripheral vascular dis.
- ❑ Arthritis: Rheumatoid/Osteo
- ❑ Liver disease
- ❑ High blood pressure
- ❑ GI Ulcers
- ❑ Blood disease
- ❑ Cancer
- ❑ Heart disease
- ❑ Varicose veins
- ❑ Epilepsy
- ❑ Hypothyroidism
- ❑ Autoimmune disease
- ❑ Rheumatic fever
- ❑ Asthma
- ❑ Eye pathology
- ❑ Charcot joint
- ❑ Leg cramps/numbness
- ❑ High cholesterol
- ❑ CVA (stroke)
- ❑ Gastric reflux
- ❑ Joint Swelling
- ❑ Joint /Muscle Pain
- ❑ Heart Attack
- ❑ Murmur
- ❑ Stint
- ❑ Chest Pain
- ❑ CHF
- ❑ HIV
- ❑ Gout
- ❑ Osteomyelitis

Other Medical problems (please list) _____

Surgical History (check only those items that apply)

- ❑ Angioplasty
- ❑ Appendectomy
- ❑ C-section
- ❑ Cataract
- ❑ Carotid artery sx
- ❑ Gall bladder sx
- ❑ D and C
- ❑ Arterial by-pass sx
- ❑ Heart by-pass
- ❑ Open heart sx
- ❑ Hysterectomy
- ❑ Hernia repair
- ❑ Hip replacement
- ❑ Knee replacement
- ❑ Mastectomy
- ❑ Kidney stone sx
- ❑ Kidney removal
- ❑ Pacemaker/Defibrillator
- ❑ Tonsillectomy
- ❑ Prostate sx
- ❑ Venous ligation
- ❑ Breast biopsy/lumpectomy
- ❑ Back surgery
- ❑ Joint replacement

Other Surgery (please list) _____

Medications (please list) _____

_____

_____

Allergies (please check)

- ❑ Novocain
- ❑ Aspirin
- ❑ Codeine
- ❑ Penicillin
- ❑ Cortisone
- ❑ Adhesive tape
- ❑ Sulfa
- ❑ Other _____

Reaction: _____

_____

Family History (please circle if positive)

	Diabetes	Heart disease	Cancer	High blood pressure
Mother	yes	yes	yes	yes
Father	yes	yes	yes	yes
Siblings	yes	yes	yes	yes

HOSPICE CARE: Are you CURRENTLY under the care of Hospice Yes- No **Date put in Hospice:** _____

Social History (please check)

- ❑ Alcohol
- ❑ Tobacco____ ppd
- ❑ Caffeine
- ❑ Activities _____

SIGNATURE: _____ DATE: _____