Bluegrass Foot Center
Dr. Steven Block
1901 Leitchfield Road, Suite B
Owensboro, KY 42303
1-270-684-5252

Please arrive 20 minutes prior to your appointment

***All services rendered in the office at the time of service will be expected to be paid for that day ***

Things to bring to your appointment:

1. Photo ID
2. Insurance Card(s)
3. New patient paperwork
4. Updated medication list

MEDICAL HISTORY

Your Name: _____ _____ _____
(Last) *(First)* *(M.I.)*
Height _____ *Weight*_____

Family Physician: _____ *Phone:* _____

Physician's Address: _____*City:*_____*State:*_____

Specialist _____For what condition?_____

Are you currently working? YES / NO / Retired (Employer_____ Type of job_____)

What type of foot/ankle problem are you having?_____(use back of page if necessary)

Have you ever been diagnosed with: (please circle) In blank please specify type where indicated

Anemia	Degenerative arthritis	Hepatitis	Osteoporosis
Asthma	Diabetes	HIV	Rheumatic fever
Autoimmune dz_____	Emphysema (COPD)	Hypothyroid	Rheumatoid arthritis
Bladder Probs_____	Fibromyalgia	Jaundice	Scoliosis
Brain/nervous dz_____	Gout	Joint Replacement Surg	Seizure (most recent)
Breathing Prob_____	Heart Attack	Kidney Prob_____	Stomach Prob_____
Cancer (type_____)	Heart Probs/Chest Pain	Liver dz_____	Stroke
Circulation problems	Hypertension	Low Blood Sugar	*NONE OF THE ABOVE*
Coronary artery disease	High Cholesterol	Lung Dz_____	

Do you smoke? YES / NO If no, have you ever smoked? YES / NO
If yes, how much per day? Estimated___(#) packs per day for _____(#) years Quit _____(year)

Do you have a chronic cough? YES / NO

Are you a menstruating female? YES / NO
Are you currently nursing? YES / NO Is there any possibility that you may be pregnant? YES / NO

Are you a Diabetic? YES / NO If yes, for how long?_____
If yes, are you or have you ever been on insulin? YES / NO If yes, for how long? _____

Do you currently receive Homehealth Care or Skilled Nursing YES / NO Facility Name_____

Please list the most recent glucose level and the date it was taken: _____
Please list the range of your average glucose level: _____

Are you currently taking a blood thinner such as aspirin, coumadin, xarelto, plavix or ticlid? YES / NO
Do you have any allergies to iodine or shellfish? YES / NO
Please list all medications that you are currently taking. *(use back of page if necessary)*
_____
_____
_____
Are you allergic to any medication? (If yes- please specify)_____

Have you ever been [or] are you currently disabled? YES / NO

If yes, For what condition (be specific)?_____

How long have you been disabled?_____

MEDICAL HISTORY, CONTINUED.

_____
Name

Please list your Family Medical History:
(mother, father, brothers, sisters, aunts, uncles, grandparents)
diabetes, heart disease, hypertension, cancer, arthritis, depression, liver disease, gout, etc.

Have you ever had an injury/fracture/sprain/break? YES / NO
If yes, please provide location/date/duration of above:

Have you ever had surgery? YES / NO An overnight hospital stay? YES / NO
If yes, please list your surgeries/hospital Stays: [please provide dates if possible]

Have you ever had an addiction to drugs or alcohol? YES / NO
If yes, please provide specifics:

Have you ever been a patient in a pain treatment program? YES/ NO
If yes, please provide specifics: