

LILY PAN PERKINS, D.P.M.
COMPREHENSIVE FOOT & ANKLE SURGERY, PLLC
550 HERITAGE DRIVE, SUITE 140
JUPITER, FL 33458
(561) 799-9581

Patient Name _____ Date of Birth _____

Florida Address _____ City _____ State _____ Zip _____

Out of State Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone# _____

Marital Status _____ Social Security Number _____ Male _____ Female _____

Guardian for Minor less than 18 years old _____

Employer name/ phone number _____

Spouse's name/number _____ Emergency Contact _____

Family Doctor name and phone number _____

Drug Store name and phone number _____

How did you hear about our office? _____

I give permission to Lily Pan Perkins, D.P.M. to release any information requested by my insurance company. I also give permission for Dr Pan Perkins to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to Lily Pan Perkins, D.P.M. for service provided.

Patient/Guardian Signature

Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle and leg) _____

When did it start? _____

What treatment have you tried before?

Have you seen a Podiatrist before? Please indicate what foot/

If yes, Name _____

ankle problems you have or had in the past?

Last Visit _____

Ankle Pain _____

Athletes Foot _____

Bunions _____

Corns and Calluses _____

Numbness Foot/leg _____

Flat Foot _____

Foot/Leg Cramps _____

Heel Pain _____

Ingrown Toenails _____

Plantar Warts _____

Swelling Ankles/Feet _____

Tired Feet _____

Other _____

ALLERGIES

- ___ Adhesive Tape
- ___ Aspirin
- ___ Codeine
- ___ Demerol
- ___ Iodine
- ___ Local Anesthetics
- ___ Novocaine
- ___ Penicillin Other _____

MEDICATIONS

Please list all medications with dosage and strength

MEDICAL HISTORY

- ___ Diabetic
- ___ Circulatory Problems
- ___ Epilepsy/Seizures
- ___ Stroke
- ___ High Blood Pressure
- ___ Low Blood Pressure
- ___ Stomach Ulcers
- ___ Heart Disease
- ___ Phlebitis
- ___ Respiratory Disease
- ___ Artificial Heart Valve/Joints
- ___ Blood Clot/DVT
- ___ Bleeding Disorders
- ___ Cancer/Type _____
- ___ Liver Disease
- ___ Aids/ HIV
- ___ High Cholesterol
- ___ Anemia
- ___ Arthritis
- ___ Gout
- ___ Hepatitis
- ___ Kidney Problems
- ___ Depression
- ___ Varicose Veins
- ___ Hypothyroidism
- ___ Glaucoma
- ___ Anxiety
- ___ Other _____

SURGICAL HISTORY

Please list any surgeries you have had

SOCIAL HISTORY

Do you smoke _____ Amount _____ per day / week

Do you drink alcohol _____ Amount _____ per day / week

SHOE SIZE _____ WIDTH _____