DR. WILLIAM RUBIN

PATIENT HISTORY FORM
Please complete as fully as possible

31046 UTICA RD.
FRASER, MI 48026
(586) 294-5010

please print

DATE:_____

Patient's name_____/Spouse_____

Address_____City_____ Zip_____

Home Phone _____Business Phone _____

Date of Birth _____ Marital Status _____

Occupation _____ Employer _____

Guardian's Name (if patient is a minor) _____
Guardian's Address_____
Person to contact in case of emergency _____Phone _____

Insured by _____ Social Sec. No. _____

Group No. _____Contract No. _____

Medicare No. _____ Are you here due to an injury? _____

What is your foot Problem? _____

_____

_____

When did this problem start? _____ Is it getting worse? _____

Have you treated this problem at home, and if so, how? _____

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

What was the treatment? _____

_____

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

What type of work do you do? _____

Your: Height:_____ft_____in Weight _____Shoe size _____
Are you in: ( ) Good health ( ) Fair health ( ) Poor health
Are you subject to prolonged bleeding or healing difficulties? _____

How did you discover our office? _____

- over -

Name _____

Welcome to our office. Please fill out this form so that Dr. Rubin may become better acquainted with you. If you need any help, please do not hesitate to ask for assistance.

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

_____

_____

Physician's name and address: _____

What medications are you taking, ***and why***? _____

_____

Are you on a diet? ( ) Yes ( ) No
Are you pregnant or trying to be pregnant? ( ) Yes ( ) No

( ) I am NOT allergic to anything to my knowledge.
( ) Yes, I am allergic to (please check):

_____Aspirin	_____Latex	_____Sutures	_____Merthiolate
_____Novocaine	_____Iodine/Betadine	_____Adhesives/Tapes	_____Nylon/Plastics
_____Codeine	_____Sulfa/Eggs	_____Demerol	_____Anti-histamines
_____Penicillin	OTHER: _____		

Do you smoke? ( )Yes ( )No How much? _____ For how long? _____
Do you have a history of alcohol or substance abuse? ( )Yes ( )No

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

_____Diabetes	_____Bleeding tendencies	_____Epilepsy	_____Heart trouble: _____
_____Stroke	_____Nervousness	_____HIV-Aids	_____Varicose Veins
_____Asthma	_____Glaucoma	_____Anemia	_____Kidney trouble
_____Gout	_____High Blood Pressure	_____Polio	_____Stomach Ulcers/Problems
_____Hepatitis	_____Tuberculosis	_____Tumors	_____Arteriosclerosis/Poor circulation
_____Arthritis	_____Cancer: type of cancer: _____		
_____Osteoporosis	OTHER ILLNESS: _____		

Do you have any family members with Diabetes? _____
Is there anything else we should know? _____

I hereby give my permission to Dr. Rubin to diagnose, to administer treatment, and to perform such procedures as appropriate in the diagnosis and/or treatment of my foot/ankle (and related) conditions:

Date: _____

_____
Signature of patient

_____
Parent or Guardian (if patient is a minor)