Limons Foot & Ankle Care

Welcome To Our Office

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

11065 Gatewood Drive, Unit 102
Lakewood Ranch, Fl 34211
Tel.: (941)782-8639
Fax: (941)243-3605

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: _____

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: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____ Subscriber Employer Work Number: _____

Subscriber Employer Address: _____

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

Secondary Insurance: _____ Subscriber (Insured) Name: _____

Patients Signature: _____ Date: _____

LIMONS FOOT & ANKLE CARE

Mr. Mrs. Ms. Miss. (Circle One)
Patient Name: _____ Birth date: _____ Shoe Size: _____

Reason for visit: _____ Date of Onset: _____

Primary Care Physician: _____Date Last Seen: _____

Former Podiatrist: _____ Date Last Seen: _____

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

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
- ❑ Joint/Muscle Pain
- ❑ 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
- ❑ Cancer Type:_____
- ❑ Heart Attack
- ❑ Murmur
- ❑ Stint
- ❑ Chest Pain
- ❑ CHF
- ❑ HIV
- ❑ Gout
- ❑ Osteomyelitis
- ❑ Other:_____
- ❑ _____

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:_____
- ❑ _____ _____ _____ _____

Medications: Please list:

MEDICATION NAME	DOSAGE	FREQUENCY	PERSCRIBING DOCTOR

Pharmacy Name:_____ Address: _____Phone: _____

Allergies (please list)
_____

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/HOME HEALTH: Are you CURRENTLY under the care of hospice/home health? YES or NO (circle one)
Facility Name: _____ Date put in hospice/home health: _____

Social History (please check)

- ❑ Alcohol ❑ Tobacco____ PPD ❑ Caffeine
- ❑ Activities_____