



Family Foot & Ankle Care
Philip C. Caswell, D.P.M.
 Diplomate, American Board of Podiatric Surgery
 Board Certified in Foot Surgery
 Fellow, American College of Foot and Ankle Surgeons

122 North Church Road (Route 94), Sparta, NJ 07871

Phone (973) 300-9151 Fax (973) 300-9175

MEDICAL HISTORY

Name: _____ Date: _____

Please describe the foot problem you are having: _____

Allergies to Medications, X-Ray dyes, or other substances: NO YES
 (If yes, please list the name of the medicine and type of reaction):

Please **CIRCLE** if you have had problems with or are presently complaining of any of the following:

- | | | | | |
|---------------------|-------------------------|-------------------------|---------------|---------------------|
| CHICKEN POX | MEASLES | MUMPS | POLIO | DIPHTHERIA |
| HEPATITIS | TUBERCULOSIS | RHEUMATIC FEVER | SCARLET FEVER | THYROID PROBLEMS |
| KIDNEY DISEASE | URINARY TRACT INFECTION | PHLEBITIS | HIATAL HERNIA | ANEMIA |
| GOUT | ASTHMA | ARTHRITIS | EPILEPSY | HIGH BLOOD PRESSURE |
| LOW BLOOD PRESSURE | HEART DISEASE | CORONARY ARTERY DISEASE | HEART ATTACK | ANGINA |
| SHORTNESS OF BREATH | STROKE | CANCER | DIABETES | ANY BLOOD DISORDERS |
| SICKLE CELL ANEMIA | THROMBOCYTOPENIA | | | |

ANY OTHER MEDICAL CONDITIONS? _____

PLEASE LIST AND SUPPLY THE DATES OF:

Operations: _____
 Hospitalizations other than for surgery: _____

MEDICATIONS (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

| Drug name | Dose | Drug name | Dose |
|-----------|-------|-----------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

I authorize the release of all medical information necessary to process claims, including by electronic means if available and request benefits be paid to Dr. Caswell. I do understand that I am responsible to pay my deductible, co-payment, and any charge for non-covered services.

Signature: _____