GERALD L. DOWLING, D.P.M.
316 S COLUMBIAN
BAY CITY, MICHIGAN 48706
(989) 686-2331

First and Last Name Middle Initial _____ What do you Prefer to be Called?

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Date of Birth _____/____/_____ Age ____ Social Security # _____/___/_____ Gender _____ Marital Status _____

Race ___Not Specified
___ American Indian ___ Asian ___ Alaska Native
___ Black/African American ___ Native Hawaiian ___ White

Ethnicity __Not Specified
___Hispanic/Latino
___Not Hispanic/Latino

Employment
__ Full Time __ Part Time __Retired

Employer Name? _____

Emergency Contact Name _____ Relationship _____ Home Phone _____ Cell Phone _____

Primary Care Physician _____ Office Phone ____-____-_____

Referred By:
__Friend __Internet __Family
__Phone Book __Physician

PRIMARY INSURANCE
Insurance Name _____

Insured Name _____ Relation to Insured _____

Insured Date of Birth _____/_____/_____ Social Security# _____-____-_____

SECONDARY INSURANCE
Insurance Name _____

Insured name _____ Relation to Insured _____

Insured Date of Birth _____/_____/_____ Social Security# _____-____-_____

Privacy Information
Name of person who can have access to your records: _____

I do hereby attest that this information is true,accurate and complete to the best of my knowledge. I understand that any falsification,omission,or concealment of any material may subject me to fees for services and/or other liability. I also understand that I am to notify Dr. Dowling of any changes to the above information.

Name of Patient or Legal Representative _____ Signature _____ Date _____

CURRENT MEDICAL HISTORY

Last Name:_____ Legal First Name:_____MI:_____

Date of Birth:_____ Age:____ Gender_____Weight_____ Height_____ Shoe Size_____

PCP or Referring Physician_____Phone_____Date Last Seen_____

Reason for visit with us_____

Current Problem

Location: __Bottom of __In Between __Inside of foot __Left __Right __Top of Foot

Site: __Ankle __Arch __Ball of Foot __Calf __Heel __Toe __Other:_____

Started: __Today #___Days #____Weeks #____Months #____Years

When does problem occur: __At night __In AM __Constant __ Off and On __Rare
__Recurrent __Other _____

Pain Scale: (circle) 0 1 2 3 4 5 6 7 8 9 10

Caused By: __Barefoot __Fall __Increased Activity __Injury __Running __Walking

Feels Like: __Aching __Bruised __Cramping __Deep __Dull __Improving __Inflamed

__Itchy __Numb __Sharp __Swollen __Tender __Tingling __Other_____

Better With: __Compression __Elevation __Heat __Ice __Medication __Rest __Shoes

Worse With: __Increased Activity __In Shoes __No Shoes __Running __Walking

Current Conditions-mark none if condition below does not apply

Symptoms: __None __Chills__Excessive Weight Gain/Loss __Fatigue__Fever__Loss of appetite
__Night sweats__Back pain__Dementia__Diabetes__Fatigue__Headaches__Infection
__Muscle spasm__Osteoporosis__Overweight__Swelling__Wear orthotics __Other_____

Eyes: __None __Double Vision __Dry eyes __Loss of vision __Pain __Redness __Other _____

Ears,Nose,Throat: __None __Ear pain __Ear ringing __Dizziness __Hearing loss __Hoarseness __Loss of smell

Heart: __None __Chest Pain __Rapid Heart Rate __Shortness of Breath __Swelling in legs or feet

Respiratory: __None __Productive cough __Shortness of breath __Snoring __Sleep apnea __Wheezing

Intestinal: __None __Abdominal Pain __Bloating/Gas __Constipation __Diarrhea __Nausea __Vomiting

Urinary/Reproductive: __None __Blood Urine ___Urinary incontinence __Pregnant __Hysterectomy
__Tubal Sterilization

Musculoskeletal: __None __Artificial joints __Soft tissue Pain __Weakness __Other _____

Skin: __None __Ingrown nail __Lesion __Non Healing Wound __Rash __Ulcer __ Wart __Other _____

Neurological: __None __Memory loss __Migraines __Numbness __Paralysis __Seizures __Strokes

Psychiatric: __None __Anxiety __Claustrophobia __Depression __Hallucinations __Restlessness

Endocrine: __None __Cold intolerance __Diabetes __Excessive thirst __Excessive Urination __Heat intolerance

Hematological: __None __Anemia __Blood Transfusions __Easy Bruising __Prolonged Bleeding __Other_____

Immunologic: __None __Allergies __HIV __Recurrent infections __ Other_____

Past Medical History -mark none if history below does not apply

__None __Anxiety __Arthritis __Asthma __Bleeding disorder __Blood clots __Callus Formation __Cancer
__Chemotherapy __Circulation problems __Depression __Diabetes __Fibromyalgia __Foot Ulceration __Gout
__Heart attack __Heart disease __Hepatitis __High blood pressure __Kidney disease __Liver disease __Lupus
__Lung disease __Neuropathy __ MRSA infection __Osteoporosis __ Pain in legs/feet/toes __Seizures
__Stomach ulcers __Stroke __Swelling in legs/feet __Thyroid disorders __Other _____

PHARMACY AND CURRENT MEDICATIONS

Pharmacy: _____Phone: _____

Medications:

ALLERGIES: __None __Adhesive Tape __Anesthetics; local __Aspirin __Blood thinners __Codeine __Dairy __Eggs
__Demerol __Iodine __Latex __Penicillin __Sulfa __Other _____

PREVIOUS SURGERIES: Foot: __Amputation __Bunion __Hammer toe __Ingrown nail __Neuroma __Orthotics

Other Surgeries:

FAMILY HISTORY: __ Cancer __Diabetes __Heart Disease __Kidney disorder __Liver disease __M.I. __CVA
__Arthritis __Hypertension __ Other_____

Caffeine History: __None __Less than 7 cups per week __More than 7 cups per week __Quit using caffeine

Alcohol History: __None __Less than 7 drinks per week __More than 7 drinks per week __Quit using alcohol

Smoking History: __Never a smoker __Former Smoker __Unknown if ever __Current every day smoker
__<1 pack a day __1 pack per day __2 packs per day __>2 packs a day
Number of years as a smoker _____

Recreational Drug History: __Never used recreational drugs __Used recreational drugs __Currently using drugs
__Been treated for substance abuse