Timothy M. Fisher, DPM

4112 Laramie Street
Cheyenne, WY 82001
Phone: (307) 514-9901
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PATIENT INFORMATION

Rev. 9-23-21

NAME ____ **TODAY'S DATE** ____________________
FIRST MIDDLE LAST

BIRTHDATE _______________ **EMAIL**_____________________________ ☐ **MALE** ☐ **FEMALE**

STREET ADDRESS _____________________________________ **CITY** ______________ **STATE**_____________

ZIP__________ **HOME PHONE ( )** _________________ **CELL PHONE ( )** _________________

SCHOOL OR PLACE OF WORK ____
BUSINESS NAME CITY

WORK PHONE ( ) ________________________ ☐ **FULL-TIME** ☐ **PART-TIME** ☐ **RETIRED**

CONTACT IN EMERGENCY ____________________________**Phone**___________________________________

How did you learn about us? (Please mark all that apply.)

FRIEND (FULL NAME) _____________________ INTERNET (where) __________________________ ☐ YELLOW PAGES

RELATIVE (FULL NAME) _________________ DOCTOR (NAME) __________________☐ NEWSPAPER ☐ OTHER ______

PREFERRED PHARMACY: ____

SUBSCRIBER'S INSURANCE INFORMATION (ONLY IF DIFFERENT FROM PATIENT)

SUBSCRIBER____ ☐ Spouse ☐ Parent/Guardian
FIRST MIDDLE LAST

STREET ADDRESS ____________________________**CITY** ___________**STATE** ____ **ZIP**__________________

HOME PHONE ( ) ___________________ **WORK PHONE ( )** ______________________________________

BUSINESS NAME ____

SUBSCRIBER'S BIRTHDATE _____________________________

RELEASE OF INFORMATION: I authorize Advanced Foot Care to release medical information to my insurance company and authorize insurance payment to Timothy M. Fisher, DPM. I understand I am financially responsible for all charges not covered by my insurance and that payment for services not covered is required at the time of service.

PATIENT SIGNATURE ____ **DATE** _________________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered or provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

PATIENT SIGNATURE____ **DATE**_________________________

Over 18 years of age, I will allow access to my medical records by : ☐ spouse ☐ parent ☐ other ☐ none

Timothy M. Fisher, DPM

313 W. Drake Road
Fort Collins, CO 80526
Phone: (970) 225-5027
Fax: (970) 797-7296

What is your main foot problem today? ____

____

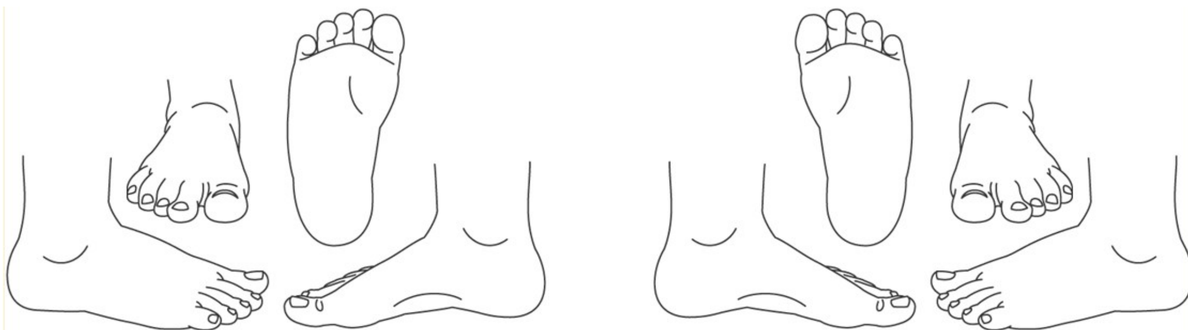
Do you have any other foot problems that need attention? ______________________________

____

History of Present Illness

Mark the problem areas on the diagrams below:

Right Foot **Left Foot**



When did your main problem begin?__________ ☐ **Days** ☐ **Weeks** ☐ **Months** ☐ **Years** **ago.**

Describe your pain: ☐**Burning** ☐**Throbbing** ☐**Sharp** ☐**Dull** ☐**Tingling** ☐**Numbness** ☐**Itching** ☐**Other**____

Is the pain due to an injury? ☐ **I have no pain** ☐**Not sure** ☐**No** ☐**Yes (If Yes, please explain)**

____

____

Have you already seen any healthcare provider for this issue(s) before today? (circle one) YES NO

What previous treatments have been used?

☐**Medications** ☐**Icing** ☐**Soaking** ☐**Stretching** ☐**Inserts/orthotics** ☐**Shoe Changes** ☐**Prior procedure** ☐**Surgery**

☐**(Ankle) bracing** ☐**Toe spacers** ☐**Injections (cortisone)** ☐**Resting** ☐**Other**_________________________________

Treatment Details: ____

____

Your Stats

HEIGHT __________________ **WEIGHT** ___________ **AGE** ______ **SHOE SIZE** ______________

NAME OF YOUR PRIMARY CARE PROVIDER: ____

Please list your current medications:

DRUG	DOSE	DRUG	DOSE	DRUG	DOSE
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______

Please check any allergies that you have:

☐ NO KNOWN ALLERGIES
☐ PENICILLIN
☐ SULFA
☐ TETRACYCLINE
☐ CEPHALOSPORINS
☐ ERYTHROMYCIN
☐ ASPIRIN
☐ CODEINE
☐ DEMEROL
☐ IODINE
☐ TAPE
☐ FOODS ______________
☐ OTHER ______________
____
____

Please check any of the following medical conditions you have had:

☐ ALCOHOLISM
☐ ANEMIA
☐ ASTHMA
☐ BACK PAIN
☐ BLEEDING DISORDERS
☐ BLOOD CLOTS (DVT)
☐ CANCER______________
☐ COPD
☐ DEMENTIA
☐ DEPRESSION
☐ DIABETES (Type I or Type II)
☐ DRUG ADDICTION
☐ EPILEPSY
☐ FIBROMYALGIA
☐ FOOT ULCERS
☐ GOUT
☐ HEART DISEASE
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV
☐ JOINT REPLACEMENT
☐ KIDNEY DISEASE
☐ KNEE PAIN
☐ MENTAL ILLNESS
☐ MULTIPLE SCLEROSIS
☐ NERVOUSNESS
☐ OSTEOARTHRITIS
☐ PHLEBITIS
☐ PERIPHERAL NEUROPATHY
☐ RAYNAUD'S DISEASE
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ STOMACH ULCERS
☐ STROKE
☐ THYROID DISORDER
☐ OTHER ______________

Do you use tobacco YES NO
If YES, what type and how much daily? ____
How long has it been since you quit tobacco? __________________________________
About how much alcohol do you drink weekly? ___________________________________
Do you use any other substances? YES NO

Please sign authorization:
I authorize Dr. Timothy M. Fisher to perform examination, evaluate, and treat my foot/ankle problems.

SIGNATURE ____ DATE ________________