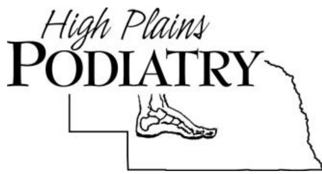

306 West D
McCook, NE 69001
(308)345-3773

725 Burlington
Holdrege, NE 68949
(308)995-4044

Robert C. Hinze, D.P.M.

Confidential Patient Information

Date: ________________ Social Security #: __________________________________

Name: ________________________________ Age: _______ Date of Birth: _____________ Sex: M F

Address: ___________________________ City: ________________ State: _____ Zip: ___________

Home Phone: ___________________ Work Phone: ______________ Email: _____________________

Employer: __________________________ Employer Address: __________________________________

Marital Status: Married Single Widow Divorced

Race: White Hispanic Asian Black/African American

Ethnicity: Hispanic Non-Hispanic Unknown **Preferred Language:** English Spanish

Spouse Information

Spouse Name: _________________________ Spouse Social Security #: ________________________

Spouse Employer: _____________________ Spouse Employer Phone: ________________________

Referral Information

Referred by: ____

Primary Physician: __________________________ Date last seen by primary physician: _____________

Miscellaneous Information

May we call you at work? YES NO

May we call you at home? YES NO

May we leave a message on your answering machine? YES NO Don't have one

Person **not** living with you in the event of an emergency: ______________________________

Relation to patient: ________________________ Phone: ___________________________

Current Height: ___________ Current Weight: ___________ Shoe Size: _________ Width: _______

Pharmacy:__________________________________ City, State: ________________________

PLEASE COMPLETE BACK OF FORM

Health Information

1. Are you having any pain or discomfort at this time? If yes, where? YES NO

   ____

2. Have you been under the care of a medical doctor or been a patient in the hospital during the last 2 years? YES NO
   If yes, for what? ____

   Have you ever had surgery? YES NO
   If yes, please specify: ____

3. Are you currently taking any medications? YES NO
   If yes, please list current medications: ________________________________

   ____

   ____

4. Do you have any drug or food allergies? YES NO
   If yes, please list allergies: ____

   ____

5. Have you ever had any excessive bleeding requiring special care? YES NO

6. Do you have any reason to believe you may be immunosuppressed or unable to fight infections? YES NO

7. Do you smoke? YES NO How many years? ______ How much? _______

   Are you an ex-smoker? YES NO

Circle any of the following which you have had or have at the present time:

Alzheimer's Disease	Drug or Alcohol Addiction	High Blood Pressure	Stroke
Anemia	Emphysema-COPD	Kidney Trouble	Thyroid Disease
Angina Pectoris	Epilepsy or Seizures	Liver Disease	Tuberculosis
Arthritis	Fainting or Dizzy Spells	Lung Disease	Ulcers
Artificial Heart Valve	Glaucoma	Motion Sickness	Venereal Disease
Artificial Joint	Hay Fever	Pacemaker	Yellow Jaundice
Asthma	Heart Disease or Attack	Psychiatric Treatment	
Blood Transfusion	Heart Murmur	Radiation	
Chemotherapy	Heart Surgery	Rheumatic Fever	
Diabetes	Hemophilia	Sickle Cell Disease	
	Hepatitis	Sinus Trouble	

I understand the information I provide on this form is essential to determine my podiatric needs and the provision of the treatment. I understand that if any change occurs in my health I will report it to the office as soon as possible. I have read and understand these questions and answered them truthfully and to the best of my ability, and I have had an opportunity to discuss my health history with the doctor.

Signature of Patient/Parent/Guardian: ______________________________ Date: ____________