DR. LANCE D. BARRY, P.C.
TRIPLE BOARD CERTIFIED*
FOOT & LEG SPECIALIST
18 Felton Place Cartersville, Georgia 30120
770-386-8620
www.tripleboardcertified.com

Referring Physician:

Reason for Referral:

Notes:

Please bring this completed form along with the following items to your appointment:

1. Insurance Card
2. Referral
3. List of Medications

If you cannot complete the paperwork in our office, please pick it up early or bring someone with you to your appointment who can help.

Patient Medical History

Today's Date: Time:

Patients Name
Title *First* *Middle* *Last*

Address
Street *City* *State* *Zip*

Home Phone Social Security #

Birth Date Age

Marital Status Gender

Patients Height Weight Shoe Size Dexterity R/L

Employer

Work Phone Date Hired

Responsible Party Information

Guardian/Caregiver /Self

Address of above if different

Relationship to Patient Home Phone

Social Security Number Birth Date

IS THIS A WORKMAN'S COMPENSATION INJURY? ☐ Yes ☐ No
If yes inform staff

Who do we thank for referring you to our office?

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier, any information for this or a related Medicare or other insurance claim. I permit a copy of this autorization to be used in place of the original, and request payment of medical insurance benefits to my physician. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible to the physician for charges not covered by this agreement or that are above the usual and customary. All deductible co-pays and applied percentages are due on the day of treatment. I have read or had read to me the above information and understand my repsonsibilities.

Signature Date

Patient Medical History *Check all that apply*

☐ AIDS ☐ ANEMIA ☐ RHEUMATOID ARTHRITIS ☐ APPETITE LOSS ☐ ASTHMA ☐ GOUT

☐ BACK PAIN ☐ BLEEDING DISORDERS ☐ BLOOD CLOTS ☐ CANCER ☐ CATTERACTS

☐ CONGESTIVE HEART FAILURE ☐ DIABETES ☐ DEPRESSION ☐ EPILEPSY ☐ GASTRIC REFLUX

☐ GLAUCOMA ☐ HEART ATTACK ☐ HIGH BLOOD PRESSURE ☐ STOMACH ULCERS

☐ STROKE ☐ THYROID DISEASE ☐ TUBERCULOSIS

PREGNANT? ☐ YES ☐ NO

Family Physician:

Past Surgical History *Please list any surgeries that you have had.*

Have you ever been hospitalized? ☐ Yes ☐ No *If yes, for what reason*

IN CASE OF EMERGENCY PLEASE CONTACT:

Name _____ Phone _____

Medications

Please list all medications you are taking both over the counter and prescription:

_____

Drug Allergies _____

Family History

Check all that apply

	Mother	Father	Brother	Sister
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐

Mother Deceased ☐ Yes ☐ No Father Deceased ☐ Yes ☐ No

Social History

Tobacco Use ☐ Yes ☐ No

If yes, how much to you smoke _____ per day and for how many years _____

If you chew, how much _____ per day and for how many years _____

Do you drink alcohol ☐ Yes ☐ No

If so what do you drink and amount consumed per day _____

Do you use drugs ☐ Yes ☐ No If so, what drugs _____

What are your physical requirements of your job?
Standing ☐ Walking ☐ Lifting ☐ Concrete Surface ☐ Steel Toe ☐

Do you work out or run? ☐ Yes ☐ No If so how often? _____

REVIEW OF SYMPTOMS:

Head, Eyes:
☐ Double Vision ☐ Infection ☐ Seasonal Allergies ☐ Dizziness
☐ Fainting ☐ Headaches ☐ Migraine ☐ Cataracts

Ear, Nose, Throat
☐ Nose Bleeds ☐ Ringing in ears ☐ Trouble Swallowing ☐ Hearing Loss

Respiratory
☐ Emphysema ☐ Asthma ☐ Bronchitis ☐ Shortness of Breath

Cardiovascular
☐ Palpitations ☐ High Blood Pressure ☐ Murmur ☐ Congestive Failure

Gastrointestinal

☐ Hiatal Hernia ☐ Hepatitis A/B/C ☐ Reflux ☐ Gastric Ulcer
☐ Diverticulitis

Genitourinary

☐ Trouble Urinating ☐ Painful Urination

Musculoskeletal

☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Heel Pain

Dermatological

☐ Thick Toenails ☐ Painful Sores ☐ Infected/Ingrown Toenails

Neurological

☐ Stroke ☐ Tremor ☐ Seizures ☐ Burning Feet

Endocrine

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Thyroid Disease

MAP AND DIRECTIONS