

VICTOR F. McNAMARA, DPM, FACFAS, FCCWS  
BOARD CERTIFIED, FOOT SURGERY  
BOARD CERTIFIED, WOUND CARE

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_ **RACE:** \_\_\_\_\_

Reason for today's visit: *(some insurances allow only 1 problem to be paid for per visit/day)*

1) \_\_\_\_\_

How long present? \_\_\_\_\_

2) \_\_\_\_\_

How long present? \_\_\_\_\_

3) \_\_\_\_\_

How long present? \_\_\_\_\_

**IS YOUR VISIT RELATED TO A WORK INJURY? Y N**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Marital Status: S M W D

**DATE ALL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST**

-Ulcers	-Cancer	-Liver Ds.	Other
-Alcoholism	-Gout	-Hypertension	
-Anemia	-Diabetes	-Numbness	
-Anorexia	-Epilepsy	-Heart attack	
-Anxiety	-Heart Ds.	-Kidney Ds.	
-Arthritis	-Hepatitis	-Psychiatric care	
-Asthma	-HIV/ AIDS	-High Risk Behaviors	
-Stroke	-Back pain	-Bleeding disorder	

**Current Medications & Dose:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medicine ALLERGIES & Reaction:** \_\_\_\_\_

\_\_\_\_\_

**Previous Hospitalizations, Surgery & Dates:** \_\_\_\_\_

\_\_\_\_\_

How Many Packs Did/Do You Smoke? \_\_\_\_\_ Day, How Many Years? \_\_\_\_\_ Quit Yrs.? \_\_\_\_\_

Do You Drink Alcohol? Y N How Much? \_\_\_\_\_

What Type of Exercise Do You Do? \_\_\_\_\_

Job Description: \_\_\_\_\_, How Many Hrs. on Feet Daily? \_\_\_\_\_

**FAMILY DOCTOR:** \_\_\_\_\_ **DID THEY REFER YOU? Y N**

The above is complete and accurate to the best of my knowledge. I hereby give permission to Dr. McNAMARA to examine, diagnose, and treat my lower extremity.

**Patient/Parent/Guardian SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_