



Heiko B Adams, DPM, FACFAS\*  
Jacob Hord, DPM

1701 Midland Trail  
Shelbyville, KY 40065  
Office: (502) 633-FEET (3338)  
Fax: (502) 633-2704  
www.myfootcare.com

*\*Diplomate of the American Board of Podiatric Surgery*

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Dear Patient:

On behalf of the staff and myself, I would like to take this opportunity to thank you for selecting our office for your podiatry care and to say "Welcome" to our practice.

Our primary concern is the patient's overall health and comfort. We will make every effort to provide only the best professional care.

It is our hope that all visits will be prompt and pleasant so that in the future you will desire to increase our family of patients through recommendations. Since it may be more convenient for you to fill out the information sheets before coming to our office, we have enclosed them in this packet.

**To assist us in your care, please bring:**

- 1. A list of any prescribed medications you are presently taking.**
- 2. A list of all surgeries you have ever had with the approximate date of when the surgery occurred.**
- 3. A referral for the visit if your insurance requires one.**  
**\*\*\*Your appointment will have to be rescheduled if you do not have the proper referral info.**
- 4. Picture ID & Insurance card(s)**
- 5. Co-Payment at check-in.**

If at anytime you have questions we will do our best to answer them.

Thanks again for selecting us for your podiatry care.

Sincerely,

Heiko B. Adams, DPM, FACFAS  
Jacob Hord, DPM



**MEDICAL HISTORY**

Check (√) any of the following you have, or have had a problem with in the past:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Eye problems           | <input type="checkbox"/> Phlebitis                     |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Fainting/Dizziness     | <input type="checkbox"/> Psychiatric Disorders         |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Foot or Leg Cramps     | <input type="checkbox"/> Respiratory Disorders         |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Frequent Infection     | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Back Problems        | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Stomach Ulcers                |
| <input type="checkbox"/> Blood Clots (DVT)    | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Swelling of the feet/ankles   |
| <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Unexpected fever/ weight loss |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Varicose Veins                |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Venereal Disease              |
| <input type="checkbox"/> Ear Problems         | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Nose Problems          | <input type="checkbox"/> None                          |

**Women Only:** Are you pregnant?  Yes  No    Breastfeeding?  Yes  No    Oral Contraceptives?  Yes  No

**PAST SURGICAL HISTORY**

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**HEALTH HABITS**

- Check (√) which one you use and how much.
- Alcohol \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Street drugs \_\_\_\_\_
- Caffeine \_\_\_\_\_
- Other \_\_\_\_\_

**MEDICATIONS**

Drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Anesthetics |
| <input type="checkbox"/> Adhesive Tape  | <input type="checkbox"/> Iodine      |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Seafood     |
| <input type="checkbox"/> Codeine        | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Latex          | <input type="checkbox"/> Other _____ |

**FAMILY HISTORY**

Is there a family history of any of the following?

- |   |                                     |  |   |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Circulation problems of the legs |
| <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Flatfeet          |   |
| <input type="checkbox"/> Bunions              | <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Diabetes          |   |

**SIGNATURES**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever has a change in health.

_____	_____
Signature of Patient, Parent, Guardian or Personal Representative	Date
_____	_____
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient