Brian O'Carroll, DPM

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1525 E Main St, Ste B, Santa Maria, CA 93454 t: (805) 354-7990 f: (805) 354-7009

MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____

How long have you had this issue? _____

Have you seen another doctor for this problem? _____ Name: _____ When: _____

Primary Care Physician: _____ Date Last Seen: _____

Did someone refer you to us?: ☐ Primary Care Physician ☐ Hospital / ER

Another doctor: _____ Another patient: _____

Preferred Pharmacy: _____ Preferred Lab: _____

Preferred Imaging Center: _____

Medication Allergies: _____ Height: _____ Weight: _____

Past Surgeries / Approximate Date: _____

Advanced Directive: ☐ Yes ☐ No

Medical Power of Attorney?: ☐ Yes ☐ No

Tobacco Use: ☐ None ☐ Former - # of years

Current amount: _____ per day / week / month: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Falls Risk (past year): ☐ No falls ☐ Falls without injury ☐ 2+ falls with or without injury

Most Recent DEXA: ☐ Yes ☐ No

DEXA Date: _____

Please indicate any of the following conditions you have had or currently have:

☐ Alcoholism	☐ Arthritis (Osteo)	☐ Arthritis (Rheumatoid)
☐ Cancer	☐ Diabetes	☐ Gout
☐ Heart Disease	☐ Hepatitis	☐ HIV
☐ Hip/Knee Replacement	☐ Hypertension	☐ Kidney Disease
☐ Pacemaker	☐ Stroke	☐ Vascular Disease

Other: _____

Release of Information: I hereby authorize the above provider and his staff/business partners to 1) release to my insurance company and its agents all information needed to determine benefits payable for related services, 2) process insurance claims generated in the course of examination or treatment, and 3) allow a photocopy of my signature to be used to process insurance claims.

Patient/Guardian Signature: _____ Date: _____