



Foot & Ankle Wellness Clinic
of Los Angeles

ACCOUNT#: _____ DATE: _____

PATIENT'S NAME: _____ SEX: _____ BIRTHDAY: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE #: _____ EMAIL ADDRESS: _____

OCCUPATION: _____ SOCIAL SECURITY #: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____

WHAT IS YOUR MAIN FOOT COMPLAINT? _____

HOW LONG HAS IT TROUBLED YOU? _____

HAVE YOU PREVIOUSLY SEEN A FOOT SPECIALIST? _____

PLEASE LIST CURRENT MEDICAL CONDITIONS: _____

PLEASE LIST CURRENT MEDICATIONS: _____

PLEASE LIST PREVIOUS SERIOUS ILLNESSES OR SURGERIES: _____

HAVE YOU SEEN A PHYSICIAN IN THE PAST 2 YEARS? _____

IF YES, PLEASE STATE WHY: _____

PLEASE LIST ANY HOSPITALIZATIONS: _____

PLEASE LIST ALLERGIES TO MEDICATION OR FOOD: _____

PLEASE STATE PERSONAL OR FAMILY HISTORY OF **DIABETES**: _____

IF YOU ARE **DIABETIC**, HOW LONG AGO WERE YOU DIAGNOSED? _____

I HEREBY GIVE PERMISSION TO DR. SUZANNE MANCHERIAN TO EXAMINE AND TREAT MY FEET.

Signature of patient (or guardian if patient is a minor)

Date