



# Cape Fear Podiatry Associates

1738 Metromedical Drive  
Fayetteville, NC 28304  
910.484.4191

4850 Fayetteville Road  
Lumberton, NC 28358  
910.738.4811

145 Tilghman Drive  
Suite 400  
Dunn, NC 28334  
910.892.1107

403 Fairview Street  
Clinton, NC 28328  
910.484.4191

Dr. Sandra Sheehan  
Dr. Daniel Laut

Dr. Terrill Brown  
Dr. Mark Eaton

Dr. Matthew Thompson  
Dr. Shelli Brewington

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Chart #: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Gender: \_\_\_ Home Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Work Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Home Address: \_\_\_\_\_

Street

City

State

Zip

Medical Doctor: \_\_\_\_\_ Last Visit: \_\_\_/\_\_\_/\_\_\_

Referred By: \_\_\_\_\_

Occupation: \_\_\_\_\_ Type of Flooring at Work: \_\_\_\_\_

# of hours on your feet: \_\_\_\_\_

What is your foot concern?: \_\_\_\_\_

How long has this been a problem?: \_\_\_\_\_ Was there an injury involved? \_\_\_\_\_

If yes, when did it occur? \_\_\_\_\_ Was it job-related? \_\_\_\_\_

Prior treatment: \_\_\_\_\_

## Have you recently had any of the following?:

- Headaches
- Blurred Vision
- Fever
- Back pain
- Chest Pain
- Leg Cramping
- Nausea
- Diarrhea
- Excessive Thirst
- Increase in urination
- Increase in appetite
- Shortness of breath
- Pain in feet

## Mark any prior conditions:

- Diabetes:**
  - Insulin
  - Pills
  - Diet-controlled
- Fasting blood sugar: \_\_\_\_\_
- HbA1c: \_\_\_\_\_%
- High blood pressure
- Stomach ulcers
- Thyroid
- Kidney concerns
- Cancer
- Stroke
- Liver / Hepatitis
- Heart valve repl.
- Seizures
- Heart concerns
- Asthma / Emphysema
- Hemophilia
- Arthritis
- Cholesterol
- Heart murmur
- Sickle Cell
- HIV
- Depression / Anxiety
- Tuberculosis
- Blood clots
- Poor circulation

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Other illnesses not listed: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

Previous surgeries: \_\_\_\_\_

If female, chance of pregnancy?: \_\_\_\_\_

**Past Family History:**

- Diabetes
- High blood pressure
- Heart Concerns
- Blood clots
- PAD
- Limb loss

**Social History:**

- Alcohol  Yes  No  Daily  Socially
- Smoking  Yes  No
- (If yes, packs per day: \_\_\_\_\_)
- Recreational drug use:  Yes  No

I acknowledge receipt of a copy of the Notice of Privacy Practices and agree to its terms.  
I authorize the release of medical records for the purpose of processing my insurance claim.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

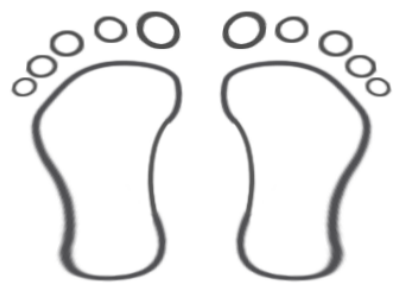
This history has been performed / reviewed by:

**Doctor:** SRS DEL TFB MTE MJT SLB **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

BP: \_\_\_\_ / \_\_\_\_  
Pulse: \_\_\_\_ BPM  
Resp: \_\_\_\_\_

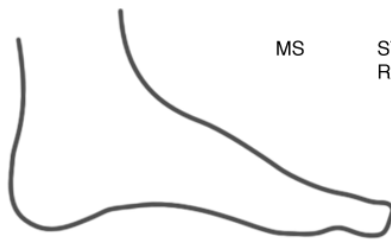


|                     |    |    |         |       |          |
|---------------------|----|----|---------|-------|----------|
| VASC                | DP | PT | CFT     | RUBOR | CYANOSIS |
| R                   | /4 | /4 | ____sec |       |          |
| L                   | /4 | /4 | ____sec |       |          |
| VARICOSITIES: _____ |    |    |         |       |          |



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TEXT  
TURGOR

MS  
STRENGTH: \_\_\_\_\_  
ROM: \_\_\_\_\_

NEURO

VIB  
LT TOUCH  
SID  
PROP

**NOTES:** \_\_\_\_\_  
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\_\_\_\_\_  
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