Richard H. Graves, DPM
Mie Shirai, DPM

304 Cherry Avenue, Long Beach, CA 90802
562-433-0478 Fax 562-438-3690

Today's Date: __________________

Patient Information

Name: ____________________________________Birth date: _______________ ( ) Female ( ) Male

Social security #:__________________________Marital status: _____________________

Street address: ____

City: ________________________________ State: ________ Zip Code: _______________

Phone:_________________________ Cell/work phone:____________________________

Employer: _________________________Work address: ___________________________

Guardian's name (if patient is a minor): ____

Address (if different): ____

Person to contact in case of emergency: ____

Relationship to patient: _____________________________ Phone: ____________________

Whom may we thank for referring you to our office?

( ) Sign/Location ( ) Yellow pages ( ) Insurance
( ) Friend/Family Member_____________________ ( ) Other: _____________________

Medical Insurance

Company: __________________________________ Policy #:
____

Name of insured: ________________________Relationship to patient_________________

Insured's date of birth ____________________ Insured's social sec # _________________

Group # ________________________ Insured's employer __________________________

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MEDICAL HISTORY

Name: ____ Age: _______________

Please briefly describe your foot/ankle problem(s): _______________________________
____
____

How long have you had the problem(s)? ______________________________________

Did you injure your foot? ____

What type of treatment have you received? ___________________________________

Have you seen a podiatrist previously? ______________________________________

If yes, for what problem? ____

Occupation: ____

Type of shoe worn at work: ________________________ Shoe size: _________________

Family physician: _______________________ Phone: _____________________________

Location: ____

Medical Conditions: ____
____

Current Medications: ____

Previous surgeries: ____

Allergies: ____

Do you use: tobacoo? ( ) Yes Amount: _________ ; alcohol? ( ) Yes Amount: ________

I hereby authorize Dr. Richard Graves and/or Dr. Mie Shirai to evaluate and provide treatment for my foot/ankle problem(s).

Patient's/Authorized signature ____
Date _______________

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Medical Questionnaire

Name: ____ Date: _______________________

Please check (x) any medical symptoms you have recently experienced or “NONE” at the end of each category.

General:
__Fever
__Chills
__Fatigue
__Weight Loss
__NONE

Skin:
__Rash
__Itching
__Scars
__Bruising
__NONE

Neurologic:
__Dizziness
__Numbness
__Weakness
__Fainting
__NONE

Head:
__Headache
__Vision Problems
__Hearing Loss
__Nose Bleeds
__Sore Throat
__Dental Problems
__Cough
__NONE

Cardiovascular:
__Stroke
__Heart Attack
__Chest Pain
__High Blood Pressure
__NONE

Lungs:
__Shortness of breath
__Wheezing
__Bronchitis
__Pneumonia
__NONE

Abdominal:
__Abdominal Pain
__Heartburn
__Constipation
__Diarrhea
__NONE

Muscles/Joints
__Arthritis
__Back Pain
__Muscle Pain
__Weakness
__ Broken Bones
__Head Injuries
__Osteoporosis
__Joint Pain
__NONE

Genitourinary:
__Urinary Frequency
__Burning on Urination
__Kidney Problems
__Sexually Transmitted Diseases
__NONE

Psychiatric:
__Depression
__Anxiety
__Substance Abuse
__NONE

Please list any other concerns or problems you have experienced and/or would like to discuss with the doctor:

____
____
____