Patient Intake Form

Personal Information:

Patient name_____ Phone #_____Age_____D.O.B_____

Primary care Physician_____ Height_____ Weight_____

How did you hear about us? _____

Pharmacy_____ Location_____

Occupation_____ Shoe size_____

What brings you in_____

_____

Past Medical History:

Are you Diabetic? _____ Do you use insulin? _____ Last A1C _____

Have you had any of the following? Hepatitis _____ HIV/AIDS_____

Circle all that apply:

Amputation	COPD/Emphysema	Neuropathy
Anaphylactic reactions	Cysts	Osteopenia
Anesthesia reaction	Cystic fibrosis	Osteoporosis
Anxiety disorder	Depression	Pacemaker
Arthritis	Fibromyalgia	Parkinson's
Asthma	Gout	Peripheral vascular disease
Atrial fib	Heart Disease	Psoriasis
Back pain	High Blood Pressure.	Pulmonary embolism
Blood clot history	High Cholesterol.	Rheumatoid arthritis
Broken bone	Hyper/hypo thyroid	Seizure disorder
Cancer_____	Irritable bowel syndrome	Sleep apnea /CPAP
Chemical addiction	Kidney disease	Stomach ulcers
Clostridium Difficile	Large scars/keloids	Stroke
Congestive Heart failure	Melanoma	Other _____

List all medications you take INCLUDING THE DOSAGE AND HOW OFTEN YOU TAKE IT. (include aspirin, birth control pills, over the counter medications and supplements.) IF YOU HAVE A MEDICATION LIST, WE CAN MAKE A COPY.

Medication	**Dose**	**How often**

1._____

2._____

3._____

4._____

5._____

Allergies (please list the reaction):

Tapes/Adhesives	Eggs	Iodine
Latex	Nickel	NSAIDS
Penicillin	Shellfish	Sulfa drugs
Contrast	Other_____	

_____

Previous surgeries (If foot or ankle surgery, please list which side):

1._____ 2._____

3._____ 4._____

5._____ 6._____

_____

Social History:

Tobacco use _____ if yes, how much?

Alcohol use _____ if yes, how much?

Illicit drug use _____if yes, which ones and how much?

Family History: Please circle all that apply

Alcoholism	Heart problems	Other _____
Amputation	Kidney disease	
Arthritis	Liver problems	
Blood clots	Lupus/autoimmune disease	
Bunions/foot deformities	Malignant melanoma	
Cancer _____	Neurologic disease	
Diabetes mellitus	Peripheral vascular disease	
Heart disease	Rheumatoid arthritis	

_____

Review of systems: Please circle any CURRENT symptoms you are experiencing.

General / constitutional: Fever chills Weight gain / loss Nausea Vomiting Diarrhea

Respiratory/ cardiovascular: Chest pain Chest tightness Cough Pain with inspiration Shortness of breath

Musculoskeletal: Arthritis/ arthralgia Back pain Limping gait Sciatica Weakness

Peripheral Vascular: Cold extremities pain Cramping in legs after walking Ulceration of feet Pain with legs elevated Edema/ swelling

Podiatric: Foot pain Ankle pain Burning/ tingling of feet Difficulty walking Foot numbness Wounds

Skin: Dry skin Changes in moles Nail changes Rash Itching

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

Signature_____ Date_____