TOWN CENTER
PODIATRY, PLLC

WELCOME TO OUR OFFICE

Today's Date: _____

Name_____ Age_____ Date of Birth ____-_____-_____ □ M □ F

Address_____

Patient Social Security # _____- _____- _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: _____ Ethnicity: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work (_____) _____

Email_____ Employer_____

Occupation_____

Family Physician: _____ Last visit date: _____

Pharmacy Name/Number: _____

Parent/Spouse's Name _____ DOB _____-_____-_____ SS# _____-_____-_____

Spouse's Employer _____

In Case of Emergency, Contact Name _____ Relationship_____

Home Phone (_____) _____ Cell Phone (_____) _____

Primary Insurance Information Policy Holders Name _____

Policy Holders DOB _____-_____-_____ Insurance Company/Phone _____

Insurance ID# _____ Group # _____

Secondary Insurance Information Policy Holders Name _____

Policy Holders DOB _____-_____-_____ Insurance Company/Phone _____

Insurance ID# _____ Group # _____

How were you referred to this office:

□Family □ Friend □ Online □ Physician: _____

REASON FOR TODAY'S VISIT: PLEASE INDICATE THE PROBLEM

What is the main Foot or Ankle problem: _____

_____

Do you have any other Foot or ankle complaint: _____

_____

HISTORY OF PRESENT ILLNESS: BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

When did your problem begin? _____

Location of the problem: _____

Is the pain: □ Burning □ Throbbing □ Sharp □ Dull □ Aching □ Other: __

What causes the problem or makes it worse? _____

Was it caused by an injury? □ No □ Yes _____

Have you treated or had anyone else treat this problem? □ No □ Yes_____

PAST MEDICAL HISTORY:

Height: _____Ft. _____in. Weight _____lbs. Shoe size _____

Major Illnesses: □ No serious past illnesses □ Diabetes □ Arthritis □ Heart Disease □ Hypertension □ Cancer: _____ □ HIV □ Hepatitis □ High Cholesterol □ Kidney disease □ Dialysis: Days _____ □ Asthma

Other: _____

Surgeries & Hospitalization: □ None □ List: _____

_____

Medications: Prescriptions: _____

_____

ALLERGY: □ Latex □ Adhesive tape □ Aspirin □ Codeine □ Iodine □ Sulfa □ Morphine □ Local Anesthetics □ Penicillin

□ Seafood Reaction Other: _____ □ NKDA

Type: □ Rash □ Trouble Breathing

FAMILY HISTORY:

Mother: □ High cholesterol □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Father: □ High Cholesterol □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Sister: □ High Cholesterol High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

Brother: □ High Cholesterol □ High blood pressure □ Diabetes □ Arthritis □ Kidney disease □ Heart attack □ Cancer

SOCIAL HISTORY: Use of: □ Tobacco Pack/Day_____ □ Alcohol How much per/day_____

□ Illicit Drugs_____

Patient Signature: _____ Date:_____

REVIEW OF SYSTEMS

General: □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping

Skin- □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes

Ears- □ Decreased hearing □ Ringing in ears □ Earache □ Drainage

Eyes- □ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □Glaucoma □ Cataracts

Nose- □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus

Throat- □ Teeth □ Dry mouth □ Sore throat □ Swollen glands □ Pain □ Stiffness

Respiratory- □ Cough □ Shortness of breath □ Shortness of breath with activity □ Swelling (edema)

Gastrointestinal- □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Constipation □ Diarrhea □Yellow eyes or skin (jaundice)

Urinary- □ Frequency □ Urgency □ Burning or pain □ Blood in urine □ Incontinence

Vascular- □ Calf pain with walking (Claudication) □ Leg cramping

Musculoskeletal- □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma

Neurologic- □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □

Hematologic- □ Ease of bruising □ Ease of bleeding

Endocrine- □ Heat or cold intolerance □ Sweating □ Frequent urination □ Thirst

Psychiatric- □ Nervousness □ Depression □ Memory loss □ Stress

Patient Name: _____ Date: _____