De La Sole Podiatric Medical Services. LLC
443-499-3758

Today's Date: ______________
Name: ____________________________________ Age: _____Date of Birth: ____________________ Circle: Male or Female
Address: _________________________________City: __________________ Zip code:_________________________________
Phone Number (Home)_____________________________ (Mobile)____
Patient Social Security Number _________________________ Marital Status:
____
Race:____ Ethnicity:____
Email:____ Phone Number:____
Occupation: ______________________________________
Primary Care Doctor:______________________________________Date of last visit:___________________________________
Pharmacy/Location/Phone Number: ____
Weight:_________________ Height:____________________ Shoe size:____

Emergency Contact Name: _____________________________Emergency Contact Number: _____________________________

Past Medical History:

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

Surgeries and Hospitalizations

If None, Check Here: _____See Attached Records Check Here: _____

Current Medication:

If None Check Here: _____ See Attached Records Check Here: _____

ALLERGY: □ Latex □ Adhesive tape □ Aspirin □ Codeine □ Iodine □ Sulfa □ Morphine □ Local Anesthetics
□ Penicillin □ Seafood Reaction Other: ____ □ NKDA
Type of reaction: □ Rash □ Trouble Breathing

Patient Name:____ Date:________________________________

Patient Name: ______________________________________ Date: ______________________________

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Reason for Todays Visit: Please indicate the problem

What is the main Foot and Ankle problem? ____

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

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

Tobacco: How much per day___________ Number of years of use______________
Alcohol: How much per day_____________Number of years of use ______________
Illicit Drugs: ____________________________________How much per day_____________ Number of years use_______

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:______________________________

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CONSENT TO TREAT: I authorize Dr. Trent and the healthcare staff to the perform the necessary services I may need
HIPPA: Please list who may communicate with regarding your private health information
Name:______________________________________ Phone:____
Relationship to you:____
INSURANCE: I authorize the release of any medical information necessary to process my insurance and also authorize my insurance company to make payment of any medical benefits to the provider for services: **De La Sole Podiatric Medical Services, LLC**. I understand that I am responsible for any portion of my bill that is not covered by my insurance

Insurance Information:
Do you have medical coverage: ☐ No ☐ Yes
Primary Coverage:____
Agreement ID #____
Insured party's name:____ Self / Spouse / Parent

SecondaryCoverage:____
Agreement ID #____
Insured party's name:____ Self / Spouse / Parent

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY: I acknowledge that a copy of the Privacy Practice will be made available to me at my request, and that I have read (or had the opportunity to read if so chose) and understood the Notice.

Print Patient Name/POA/Caregiver: ____
Patient/POA/Caregiver Signature: ____ Date: __________________________

Patient Name:_______________________________________ Date:______________________________