WELCOME TO OUR OFFICE

DATE_____

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S NAME_____**SEX**_____**FEMALE**_____**MALE**

ADDRESS_____**CITY**_____

STATE_____**ZIP**_____**HOME PHONE NUMBER**_____

PREFERRED LANGUAGE_____**RACE**_____**ETHNICITY**_____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH_____**AGE**_____**HEIGHT**_____**WEIGHT**_____

CELL PHONE NUMBER_____ **E-MAIL**_____

EMPLOYER_____**OCCUPATION**_____

EMPLOYER ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

WORK PHONE NUMBER_____

IN CASE OF EMERGENCY CONTACT_____**PHONE#**_____

MARITAL STATUS (CIRCLE) SINGLE---MARRIED---WIDOWED---DIVORCED

SPOUSE'S NAME_____**EMPLOYER**_____

REFERRED BY?_____

PERSON RESPONSIBLE FOR COST_____

HAVE YOU EVER BEEN TREATED BY A PODIATRIST BEFORE? _____**YES**_____**NO**

IF YES, WHAT WAS THE NAME OF YOUR PODIATRIST_____

NAME OF YOUR FAMILY PHYSICIAN/ADDRESS/PHONE NUMBER

_____

_____**(**_____**)**_____

CHIEF FOOT COMPLAINT?_____

HOW LONG HAS THE FOOT PROBLEM BEEN PRESENT?_____

DESCRIBE ANY PRIOR TREATMENT_____

PAGE 2 **DATE**_____

IS THERE ANY FAMILY HISTORY OF FOOT PROBLEMS(If yes, please describe)_____

_____

ALLERGIES? NONE_____**PENICILLIN**_____**NOVACAINE**_____

ADHESIVE TAPE_____**OTHER**_____

MEDICATIONS(please list)_____

_____

_____

VITAMINS/HERBAL/SUPPLEMENTS (please list)_____

ARE YOU TAKING BLOOD THINNERS(ex. Aspirin, Coumadin,etc) _____**YES**_____**NO**

IF YES, PLEASE LIST_____

PHARMACY NAME_____

PHARMACY ADDRESS_____**PHONE #**_____

SURGICAL HISTORY?_____

HAVE YOU BEEN HOSPITALIZED RECENTLY (IF YES, WHY)_____

_____

FAMILY MEDICAL HISTORY?_____

IS THERE ANY HISTORY OF DIABETES? _____

PERSONAL_____**INSULIN OR NON-INSULIN** **FAMILY**_____

DO YOU SMOKE _____**YES**_____**NO (IF YES, HOW MUCH + HOW LONG)**_____

DO YOU DRINK ALCOHOL _____**YES**_____**NO (IF YES, HOW OFTEN)**_____

DO YOU USE ILLICIT DRUGS (IF YES, WHAT AND HOW OFTEN)_____

 DATE_____

PAST MEDICAL HISTORY (PLEASE CIRCLE AND IF YES, PLEASE EXPLAIN)

ASTHMA?	YES/NO _____
BACK PAIN?	YES/NO_____
BLOOD CLOTTING ABNORMALITIES?	YES/NO_____
DIABETES?	YES/NO_____
ECZEMA?	YES/NO_____
FUNGAL INFECTIONS?	YES/NO_____
GASTRITIS?	YES/NO_____
GI BLEED?	YES/NO_____
GOUT?	YES/NO_____
HIGH CHOLESTEROL?	YES/NO_____
HIV/AIDS?	YES/NO_____
MURMUR?	YES/NO_____
ONYCHOMYCOSIS?	YES/NO_____
KIDNEY FAILURE?	YES/NO_____
RHEUMATIC HEART DISEASE?	YES/NO_____
STOMACH ULCERS?	YES/NO_____
HIGH BLOOD PRESSURE?	YES/NO_____
CANCER?	YES/NO_____

REVIEW OF SYSTEMS (PLEASE CIRCLE AND IF YES, PLEASE EXPLAIN)

ALLERGIC OR IMMUNOLOGIC SYMPTOMS?	YES/NO _____
BACK PAIN?	YES/NO_____
BLOOD CLOTTING PROBLEMS?	YES/NO_____
BREATHING OR RESPIRATORY DIFFICULTY?	YES/NO_____
CARDIOVASCULAR PROBLEMS?	YES/NO_____
CHEST SYMPTOMS?	YES/NO_____
EYE OR VISION PROBLEMS?	YES/NO_____
GI SYMPTOMS?	YES/NO_____
KIDNEY OR URINARY TRACT SYMPTOMS?	YES/NO_____
JOINT OR MUSCULOSKELETAL SYMPTOMS?	YES/NO_____
NEUROLOGICAL SYMPTOMS OR PROBLEMS?	YES/NO_____
PSYCHIATRIC OR EMOTIONAL DIFFICULTIES?	YES/NO_____
SKIN OR NAIL PROBLEMS?	YES/NO_____
EAR, NOSE, MOUTH OR THROAT PROBLEMS?	YES/NO_____

SIGNATURE_____

PHYSICIAN SIGNATURE_____