EvolvePodiatry
Dr. Jeffrey Weiland, DPM

New Patient History and Demographics

General Information

Patient Name:	DOB:	Age:	Gender:
Address:			
City:	State:	Zip Code:	
Primary Phone Number:	Secondary Phone Number:		
Email:			
Allergies:			

Emergency Contact

Name:	Contact Number:
Relationship to Patient:	Address:

Healthcare Team:

Primary Care Provider (PCP):	PCP Contact Number:
PCP Address:	
Home Health Agency:	
Pharmacy Name:	Pharmacy Address:

Do you have any of the following*:

Do Not Resuscitate (DNR)? **Yes / No**	Advance Directive? **Yes / No**
Living Will? **Yes / No**	Medical Power of Attorney? **Yes / No**

*If you answered yes to any of the above, please supply a copy for our records.

If you have any special accommodations needed, please let us know here:

_____

Medical Questionnaire:

If you were referred to Evolve Podiatry, LLC, who referred you? _____

If you have a wound:

How long have you had the wound?	
How have you been treating the wound?	
Is this your first wound of this nature?	
Have you noticed any signs of infection in your wound?	(Circle) r**edness / swelling / purulent (pus) drainage / heat / pain / odor**

If you are diabetic, please fill out the following. If you are not, please skip to the next section.

Do you have type 1 or type 2 diabetes? _____

What was your last blood sugar level and when was this checked: _____ and _____

What was your last Hemoglobin A1C and when it was drawn: _____ and _____

Do you take insulin? Yes / No

If you are seen by an endocrinologist, please list their name: _____

Have you ever been evaluated by a vascular specialist? Yes / No

If yes, please list the provider's name and your last visit date: _____ and _____

List any vascular surgeries, procedures, or tests that were completed on your legs:

_____

Past Medical History:

Check in the box if you have had any of the following:

□ Asthma	□ Congestive Heart Failure	□ Stomach Ulcers	□ Diabetic Ulcers
□ Emphysema	□ Kidney Failure	□ High Blood Pressure	□ Heart Disease
□ Diabetes	□ Kidney/Bladder Infections	□ Heart Attack	□ Stroke
□ Hepatitis	□ Bowel/Colon Problems	□ Irregular Heartbeat	□ Seizures
□ Cancer, type _____	□ Other: _____	□ Other: _____	□ Other: _____

Past Surgical History:

Surgery:	Approximate Date:	Surgery:	Approximate Date:

Social History

Marital status: Single / Married / Widowed

Living situation: With Family / Lives Alone / Lives in Medical Facility or Assisted Living Facility

Number of Children:

Do you smoke: Yes / No

If yes: How many years? ___

How many packs per day? ___

If you quit: How many years ago? ___

Do you drink alcohol regularly? Yes / No

Do you use any illicit drugs (*excluding medical marijuana)? Yes / No

If yes, what illicit drugs? _____

*If you use medical marijuana, please include in your medication list.

Family History:

Mother

□ High Blood Pressure	□ Heart Disease	□ Asthma	□ Emphysema	□ Diabetes
□ Stroke	□ Seizure	□ Cancer	□ Kidney Disease	□ Amputation

Father

□ High Blood Pressure	□ Heart Disease	□ Asthma	□ Emphysema	□ Diabetes
□ Stroke	□ Seizure	□ Cancer	□ Kidney Disease	□ Amputation

Review of Systems:

If you are experiencing any of the following symptoms, place a check in the box.

Constitutional	Hematologic/Lymphatic	Cardiovascular	Renal
□ Unexpected weight loss	□ Recent blood transfusion	□ Irregular heart beat	□ Frequent urination
□ Fever/chills	□ Anemia	□ Chest pain	□ Blood in urine
Head	□ Swollen glands	□ Shortness of breath	□ Pain during urination
□ Head trauma	□ Easy bleeding	□ Leg swelling	**Musculoskeletal**
□ Headache	□ Easy bruising	□ Leg pain/cramps	□ Pain in joints
ENT	**Pulmonary**	**Digestive Tract**	□ Pain in back
□ Change in vision	□ Coughing up sputum	□ Nausea or vomiting	**Neurologic**
□ Loss of vision	□ Coughing up blood	□ Rectal bleeding	□ Seizures
□ Difficulty hearing	□ Wheezing	□ Abdominal pain	□ Neuropathy
□ Ear pain	□ Difficulty Breathing		□ Numbness/tingling
□ Congestion			

Medications:

If you have a medication list, please provide a copy.

If you do not, please list your medications below or bring a copy to your next visit.

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency
Ex: *Aspirin*	Ex: *81 mg daily*		