PEAK
FOOT AND ANKLE

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PATIENT REGISTRATION FORM

Clear Form

PATIENT INFORMATION

Date _____

Patient Name_____
Last name

_____
First name Middle Initial

Sex: _____ Age: _____ Birthdate _____

Address_____

City _____

State _____ Zip _____

E-mail _____

Home Phone _____

Cell Phone _____

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone _____

Whom may we thank for referring you?_____

_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship_____

Home Phone _____

Work Phone_____

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints).

_____

_____

_____

Have you ever been to a Podiatrist before?
- ☐ Yes
- ☐ No

If yes, who?_____

Is there any personal or family history of diabetes?
- ☐ Yes
- ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

Please check which foot problems you now have or have had in the past.

- ☐ Ankle pain
- ☐ Athlete's foot
- ☐ Bunions
- ☐ Corns and Callouses
- ☐ Cramps or numbness in feet or leg
- ☐ Flat feet
- ☐ Heel pain
- ☐ Ingrown Toenails
- ☐ Plantar Warts
- ☐ Swelling in Ankles or Feet

MEDICAL HISTORY

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Rash	☐Yes	☐No
Allergies to Anesthetics	☐Yes	☐No	Eye Problems	☐Yes	☐No	Respiratory Disease	☐Yes	☐No
Allergies to Medicine or Drugs	☐Yes	☐No	Fainting	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Foot or Leg Cramps	☐Yes	☐No	Shortness of Breath	☐Yes	☐No
Angina	☐Yes	☐No	Gout	☐Yes	☐No	Sinus Problems	☐Yes	☐No
Arthritis	☐Yes	☐No	Headaches	☐Yes	☐No	Special Diet	☐Yes	☐No
Artificial Heart Valves or Joints	☐Yes	☐No	Heart Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Asthma	☐Yes	☐No	Hemophilia	☐Yes	☐No	Swelling in Ankles, Feet	☐Yes	☐No
Back Problems	☐Yes	☐No	Hepatitis or Jaundice	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Tired Feet	☐Yes	☐No
Cancer	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Liver Disease	☐Yes	☐No	Ulcers	☐Yes	☐No
Chest Pain	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Varicose Veins	☐Yes	☐No
Chronic Diarrhea	☐Yes	☐No	Neuropathy	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Phlebitis	☐Yes	☐No	Weight Loss, unexplained	☐Yes	☐No
Diabetes	☐Yes	☐No	Psychiatric Care	☐Yes	☐No			
Ear Problems	☐Yes	☐No	Radiation Treatment	☐Yes	☐No			

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician_____Last visit date_____

Are you now or have you been, under any other doctor’s care for any reason over the past two years? ☐Yes ☐No

If yes, please explain_____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____)_____

Do you take oral contraceptives? ☐Yes ☐No

ALLERGIES

☐Adhesive/Tape	☐Local Anesthetics
☐Anticoagulant Therapy	☐Novocaine
☐Aspirin	☐Penicillin
☐Codeine	☐Seafoods
☐Demerol	☐Sulfa
☐Iodine	

Other_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor’s assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient