LYNBROOK PODIATRY PLLC

Eugene Kim DPM

PATIENT INFORMATION

TODAY'S DATE:			FOR OFFICE USE CHART #:
LAST NAME:		FIRST:	
BIRTH DATE:	AGE:	SEX: ❑ M ❑ F	TITLE:❑ MR. ❑ MRS.❑ MISS ❑ MS. ❑ Dr.
STREET ADDRESS/ APT#:			
CITY:	STATE:		ZIP CODE:
HOME PHONE #:		WORK PHONE #:	
CELL PHONE #:		EMAIL:	
OCCUPATION:		EMPLOYER:	
EMERGENCY CONTACT NAME:		INSURANCE CARRIER & ID #:	
PHONE #:		RELATIONSHIP:	

PHYSICIAN AND REFERRAL INFORMATION

WHO REFERRED YOU TO OUR PRACTICE?

- ❑ PHYSICIAN: _____
- ❑ FRIEND: _____
- ❑ FAMILY
- ❑ CLOSE TO HOME/WORK
- ❑ INSURANCE PLAN
- ❑ INTERNET/WEBSITE
- ❑ ZOC DOC
- ❑ OTHER: _____

NAME OF PRIMARY PHYSICIAN: _____

PHONE NUMBER OF PRIMARY PHYSICIAN: _____

ADDRESS OF PRIMARY PHYSICIAN: _____

PHARMACY NAME: _____

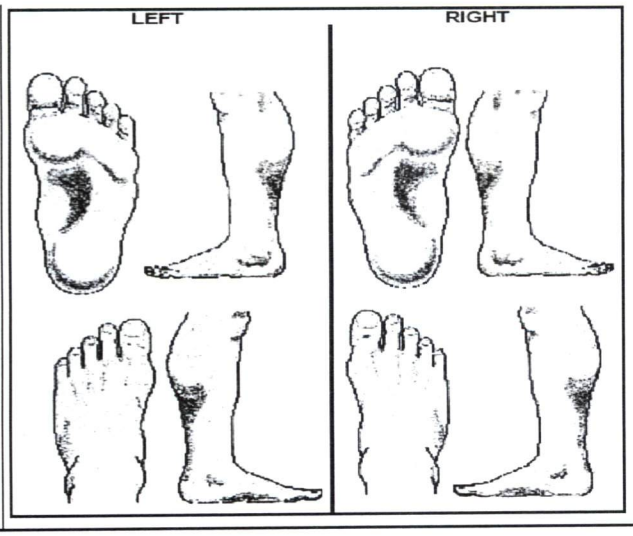
PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

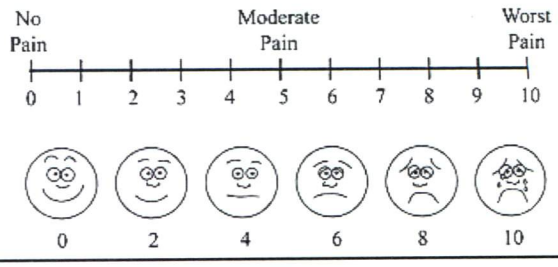
WHAT COMPLAINT BRINGS YOU TO THE DOCTOR TODAY? _____

_____

PLEASE CIRCLE THE AREA(S) THAT YOU HAVE PAIN OR ARE CONCERNED ABOUT:



CIRCLE OR MARK WHAT LEVEL OF PAIN YOU ARE HAVING:



HOW LONG HAVE YOU BEEN HAVING THIS PROBLEM? _____

HOW HAVE YOU PREVIOUSLY TREATED THIS PROBLEM? _____

PLEASE CHECK IF YOU ARE CURRENTLY BEING TREATED FOR, OR HAVE HAD, ANY OF THE FOLLOWING:

❑ ARTHRITIS	❑ CANCER (indicate if resolved):
❑ BACK PAIN	❑ BLEEDING/CLOTTING DISORDERS
❑ ARTIFICIAL JOINTS	❑ BLOOD CLOTS/DVT/PULMONARY EMBOLUS
❑ GOUT	❑ PERIPHERAL VASCULAR DISEASE
❑ DIABETES	❑ HEART DISEASE/HEART ATTACK
❑ FOOT ULCERS/INFECTION	❑ HIGH BLOOD PRESSURE
❑ NEUROLOGICAL OR NERVE DISORDERS	❑ HIGH CHOLESTEROL
❑ MIGRAINES/HEADACHES	❑ HEART MURMUR
❑ STROKE/TIA	❑ KIDNEY PROBLEMS/KIDNEY STONES
❑ HEPATITIS (circle type): A B C	❑ STOMACH ULCERS OR REFLUX (GERD)
❑ PSYCHIATRIC CARE	❑ THYROID ISSUES
❑ DEPRESSION	❑ HIV/AIDS
❑ ANXIETY DISORDER	❑ SUBSTANCE ABUSE
❑ FIBROMYALGIA	❑ OTHER:
❑ LUNG DISEASE	❑ OTHER:
❑ ASTHMA	❑ OTHER:

CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		
❑			❑		

PLEASE CHECK OR LIST ANY ALLERGIES IN THE APPROPRIATE BOX BELOW

❑ PENICILLIN	❑ LATEX
❑ CODEINE	❑ SHELLFISH
❑ ASPIRIN	❑ METALS (STEEL, NICKEL)
❑ NSAIDS (ADVIL, MOTRIN, IBUPROFEN)	❑ TAPE ON SKIN
❑ IODINE	❑ SEASONAL ALLERGIES
❑ SULFA DRUGS	❑ OTHER:

SOCIAL HISTORY

DO YOU CURRENTLY SMOKE TOBACCO CIGARETTES?	❑ YES	❑ NO
DO YOU CURRENTLY USE ANY ILLICIT DRUGS?	❑ YES	❑ NO
DO YOU CURRENTLY DRINK ALCOHOL EXCESSIVELY?	❑ YES	❑ NO
HAVE YOU EVER BEEN IN A DRUG OR ALCOHOL REHAB PROGRAM?	❑ YES	❑ NO

SURGICAL HISTORY (IF YES, LIST TYPE OF SURGERY)

❑ FOOT SURGERY	❑ CANCER SURGERY (list type)
❑ KNEE SURGERY	❑ CIRCULATION SURGERY
❑ HIP SURGERY	❑ BRAIN SURGERY
❑ BACK SURGERY	❑ ABDOMINAL SURGERY
❑ HEART SURGERY	❑ OTHER:

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF DIABETES?	❑ YES	❑ NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF HEART DISEASE?	❑ YES	❑ NO
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF BLOOD CLOTS?	❑ YES	❑ NO

REVIEW OF SYSTEMS

ARE YOU CURRENTLY HAVING OR HAVE YOU PREVIOUSLY HAD PROBLEMS WITH:
(Please check the appropriate symptoms that apply)

CONSTITUTIONAL	❑ LOSS OF APPETITE ❑ GAIN OR LOSS OF WEIGHT ❑ FEVER ❑ DIFFICULTY SLEEPING	❑ CHILLS ❑ FEELING WEAK ❑ FATIGUE
SKIN	❑ ITCHING ❑ RASH ❑ HIVES	❑ SKIN CANCER ❑ SKIN ULCER
CHEST/LUNGS	❑ CHEST PAIN ❑ SWELLING OF THE LEGS ❑ PALPITATIONS ❑ SHORTNESS OF BREATH	❑ HEART ATTACK ❑ DIFFICULTY BREATHING ❑ SLEEP APNEA
MUSCULOSKELETAL	❑ JOINT PAIN ❑ NECK PAIN ❑ BACK PAIN ❑ AMBULATORY DIFFICULTIES	❑ MUSCLE PAIN ❑ JOINT STIFFNESS ❑ SWELLING
NEUROLOGICAL	❑ FAINTING ❑ DIZZINESS ❑ MOTOR WEAKNESS ❑ CHANGE IN MOODS ❑ SEIZURE	❑ ATAXIA ❑ TINGLING/BURNING ❑ MEMORY LOSS ❑ CHANGE IN SPEECH
HEME/LYMPH	❑ ANEMIA ❑ BRUISE EASILY	❑ BLEEDING ❑ SWELLING

PATIENT ATTESTATION

I HEREBY ATTEST THAT THE INFORMATION PROVIDED IN THE REGISTRATION FORM AND MEDICAL HISTORY IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE:	DATE: