Dr. Haytham Mansour, DPM, PhD
Diplomate, American Board of Podiatric Medicine
Diplomate, American Board of Foot and Ankle Surgery

Today's Date: _____ Reason for today's visit: _____

Patient Information

Name: _____ Date of Birth: _____ Gender at Birth: M / F

Address: _____ City: _____ State: _____ Zip _____

Home Phone: (____)_____-_____ Cell: (____)_____-_____ Marital Status: _____

Occupation _____ Work/School Name: _____ Work: (____)_____-_____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____- _____

Pharmacy Name/Address: _____ Phone No.: (____)_____- _____

Primary Care Physician: _____ Date of last visit: _____

Address/City: _____ PCP Phone: (_____) _____- _____

Medical History

Allergies: (*medication and non-medication*): _____

Medications: (*presciption, over the counter, supplements)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History (*circle all that apply*): High Blood Pressure · Diabetes · Thyroid Disease · Heart Disease
Stroke · Bleeding/Clotting Disorder · Kidney Disease · Arthritis · Gout · Liver Disease · Lung Disease
HIV/AIDS · Gastrointestinal Disease · Prostate/Bladder Disease · Neurologic Condition · Vascular Disease
Depression/Anxiety · Developmental Delay · Cancer (type _____) · Other _____

Past Surgical History and Hospitalizations (*please list*):

_____

_____

Are you or could you be pregnant? YES / NO / Not applicable Shoe size: _____

Tobacco Use: YES / NO / PAST If YES or PAST, how much _____ for how long _____

Alcohol Use: NO / DAILY / SOCIAL If applicable, number of drinks per week: _____

Height: _____ Weight: _____ lbs Your Email: _____

Insurance Coverage: *Please provide insurance card(s) for scanning*

Primary Carrier : _____ Name and DOB of Insured: _____

Secondary (if applicable): _____ Name and DOB of Insured: _____

Check here if you are self pay: ☐ Responsible Party (*if patient is a minor*): _____

I attest that the information above is correct. Signature: _____