Please Print

Patient Name:_____

Date:_____

Patient Information

Patient 's Last Name	**First**	**Middle**	**Date of Birth**
Street Address	**City**	**State**	**Zip Code**
Home phone # ( )	Cell phone # ( )	Work phone# ( )	How did you hear about us?
Email:_____ **Providing your email allows you access to your medical records at any time from anywhere, just check your email for the portal invite or ask our receptionist**	Sex Male / Female	Social Security #	Marital Status ___Single ___Married ___Widowed___Divorced

Emergency Contacts

Name:	Relationship:	Phone: ( )
Name of nearest relative NOT Living with you:	Relationship:	Phone: ( )

****Family Physician Information/ Primary Care Physician** **REQUIRED FOR ALL MEDICARE/MEDICAID PATIENTS****

****Dr. Name****	****Date of last PCP visit****		
Street Address	City/Zip code	State	****Phone number**** ( )

Please provide as acurate as possible dates for the following:

Last Vaccinations	Last Pap Smear
Last Colon Screening	Last Prostate Exam
Last Mammogram	

Shoe Size: **Height:** **Weight:**	Blood pressure:	Blood Sugar:

Do you Drink? YES / NO	If yes, what type?	Drinks per week?	Former Drinker? YES / NO
Do you smoke? YES / NO	If yes, for how long?	# of packs per day?	Former Smoker? YES / NO
Drug Use? YES / NO	If yes, for how long?	What types of drug(s)?	

Allergies- List <u>ALL KNOWN</u> allergies or reactions to drugs/medications

Allergies	Reaction/Severity

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Past Surgical History

Have you ever been put to sleep for Surgery?	YES / NO	If YES, please list all surgeries:
Any Reaction to general Anasthesia?	YES / NO	If YES, please specify:

Family History- has anyone in your family ever suffered from:

		Relation	
Cancer	YES / NO		
Diabetes	YES / NO		
Heart Disease	YES / NO		
Hypertension	YES / NO		
Thyroid Disorders	YES / NO		
Other_____			

Indicate which of the following you HAVE HAD or HAVE at present:

AIDS/HIV	YES / NO	Hospitalizations	YES / NO
Anxiety Disorder	YES / NO	Hypertension/High Blood Pressure	YES / NO
Arthritis/Gout/Rheumatoid	YES / NO	Leg or Foot Ulcers	YES / NO
Artificial Joint	YES / NO	Liver Disease	YES / NO
Back Pain	YES / NO	Lung Disease	YES / NO
Bladder/Kidney Problems	YES / NO	Mental Disorder	YES / NO
Bleeding Disorder	YES / NO	MRSA Exposure	YES / NO
Blood Clots	YES / NO	Multiple Sclerosis	YES / NO
Blood Transfusion	YES / NO	Muscle, Joint or Bone Problems	YES / NO
Breast Problems	YES / NO	Neurological Disorder	YES / NO
Cancer	YES / NO	Obesity	YES / NO
Coronary Artery Disease	YES / NO	Organ Transplant	YES / NO
Diabetes	YES / NO	Prostate Disorder	YES / NO
Ear or Hearing Problems	YES / NO	Psoriasis/Skin Problems	YES / NO
Eating Disorder	YES / NO	Pulmonary Embolism	YES / NO
Edema	YES / NO	Raynaud's Disease	YES / NO
Fibromyalgia	YES / NO	Stroke	YES / NO
Foot Deformity	YES / NO	Thyroid Problems	YES / NO
Frost Bite	YES / NO	Tuberculosis	YES / NO
GI Problems/Reflux/GERD	YES / NO	Varicose Veins	YES / NO
Headaches	YES / NO	Vision/Eye Problems	YES / NO
Heart Problems/Disease	YES / NO	Other:	
Hernia	YES / NO		
High Cholesterol	YES / NO		

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Please List the name and Phone number of ANY specialist currently treating you:			
If YES, what for?	How Long? ____Months ____Years		
Have you had previous treatment by a Podiatrist?	YES / NO		
If YES, what for?			
Have you had any of the following treatments on your foot/ankle? Please note what kind			
Surgery_____	Orthotics_____	Oral Medication_____	Cortisone Shots_____

Pharmacy/Prescription Information

Preferred Parmacy:	Costco____	CVS_____	Rite Aid___	Target_____	Walmart____
Walgreens _____	ShopRite	_____	Medco	_____	Other:_____

Address/Cross Streets		City, State, Zip Code
Phone Number:	Fax:	_____This is a mail order pharmacy

MEDICATIONS please list ALL CURRENT medications that you are taking- both precription & over the counter (including vitamins)

Medication(s)	Dosage

Race/Ethnic Identificatioin: _____ Check here if you wish NOT to participate

____Native Hawaiian/Other Pacific Islander	____American Indian/Alaska Native
____African American (Non-Hispanic or Latino Origin	____Asian
____White (Non-Hispanic or Latino origin)	____Hispanic or Latino
____ Other:_____	

Primary Language:

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient Signature: Date:

For office use only- HISTORY REVIEWED BY: Date: