

We are glad to have you as a patient. Please answer the following questions to help us become better acquainted. If you need any help, please do not hesitate to ask us for assistance.

Patient Information

Last Name _____ First Name _____ MI _____

Street _____ City/State _____ Zip _____

Phone (____) _____ - _____ Cell (____) _____ - _____ Sex **M** **F**

SS # _____ - _____ - _____ Date of Birth ____/____/____ Marital Status **S** **M** **W** **D**

Emergency Contact Name _____ Phone # (____) _____ - _____

Relationship to You _____

How did you hear about our practice? _____

CIRCLE ONE: Are You Employed? **Yes** **No** May we contact you at work? **Yes** **No**

Name of Employer _____ Phone # (____) _____ - _____

Address of Employer _____

Personal Medical History

Name, address and phone number of your primary care physician _____

What is the reason for your visit today? _____

Allergies to medication _____

Other Allergies _____

Please list any medications you are currently taking _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Diabetes	Y	N	Kidney Disease	Y	N
Liver Disease	Y	N	Heart Disease	Y	N
Lung Disease	Y	N	Joint Replacement	Y	N
Stomach Problems	Y	N	Joint Pain	Y	N
Are You Pregnant?	Y	N	Bleeding/Clotting Problems	Y	N

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Hepatitis? Y N If yes, what type? _____

Any type of transplant? Y N If yes, what type? _____

Any form of cancer? Y N If yes, what type? _____

If so, have you had chemotherapy or radiation treatments? _____

Personal or family history of malignant melanoma? Y N who? _____

Any hospital admissions? Y N When and why _____

Please list any current illnesses or medical conditions _____

Is there any other information that you would like the doctor to know? _____

PODIATRIC HISTORY

Have you ever been to a podiatrist before? Y N When? _____

Name of Doctor _____ What type of treatment did you have? _____