TODAY'S DATE: / / **WELCOME TO FAMILY PODIATRY CENTER!**

Last Name: First Name:

Sex: ☐ Male ☐ Female S.S # - - Date of Birth: / /

Address: Apt/Suite: City: State: Zip Code:

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

Primary Care Physician: Primary Care Physician Phone: ( ) -

Pharmacy: Pharmacy Phone: ( ) -

Employer: Occupation:

How were you referred: ☐ PCP/Doctor ☐ Friend/Family ☐ Internet ☐ Other:

Have you had previous treatment by a Podiatrist? ☐ Yes ☐ No If yes, when? / /

What is your chief foot/ankle complaint?:

How long have you had this complaint?: Which foot: ☐ Right ☐ Left ☐ Both

If painful, what makes pain worse?: ☐ Walking ☐ Sitting ☐ Shoes ☐ Standing ☐ First step out of bed

COMPREHENSIVE PATIENT MEDICAL HISTORY

ARE YOU BEING OR HAVE YOU EVER BEEN TREATED FOR:		
☐ Diabetes	☐ Heart Attack	☐ High Blood Pressure
☐ Phlebitis	☐ Raynaud Disease	☐ Heart Condition
☐ Anemia	☐ Poor Circulation	☐ Eye Problems
☐ Stroke	☐ Kidney Disease	☐ Keloid/Thick Scar
☐ Gout	☐ Osteoporosis	☐ Alzheimer's
☐ Sciatica	☐ Lyme's Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Hearing/Ear Problem
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Asthma	☐ Lung Disorder	☐ Tuberculosis
☐ Hepatitis	☐ Liver Disease	☐ Thyroid Problem
☐ Dark Urine	☐ HIV Positive	☐ Chronic Light Stool
☐ Cancer	☐ Stomach Ulcer	☐ None of These

LIST OF ALLERGIES – SKIN OR OTHER SEVERE REACTIONS			
Are you allergic to...	Yes	No	If yes, what happens?
Penicillin	☐	☐	
Other Antibiotic	☐	☐	
Asprin, Advil, Aleve	☐	☐	
Latex	☐	☐	
Novocaine	☐	☐	
Sulfa	☐	☐	
Adhesive tape	☐	☐	
Pain Medicine	☐	☐	
Shrimp, Iodine	☐	☐	
Tylenol	☐	☐	
Other	☐	☐	

LIST OF MEDICATIONS:

Medicine:	Treatment for:

FAMILY MEMBERS WHO HAVE HAD:

Diabetes	
Arthritis	
Stroke	
Gout	
Foot Issues	
Heart Attack	
Cancer	
High Blood Pressure	

IF YES TO ANY QUESTION, PLEASE EXPLAIN FURTHER:

Are you currently pregnant?	☐Yes	☐No	If yes, when are you due?: ______/______/______
Are you slow to heal?	☐Yes	☐No	Explain:
Any abnormal bleeding?	☐Yes	☐No	Explain:
Have you had a pneumonia shot?	☐Yes	☐No	If yes, when?: ______/______/______
Have you had a flu shot?	☐Yes	☐No	If yes, when?: ______/______/______
Do you smoke now?	☐Yes	☐No	If yes, how much? Approximately ________ packs/day for ________ years
Have you ever smoked?	☐Yes	☐No	If yes, how much? Approximately ________ packs/day for ________ years
Alcoholic beverages?	☐Yes	☐No	If yes, when?: ☐ Rare ☐ Moderately ☐ Daily
Do you take coumadin?	☐Yes	☐No	If yes, since?: ______/______/______
Do you have diabetes?	☐Yes	☐No	If yes, since?: ______/______/______
Do you have and vascular grafts?	☐Yes	☐No	If yes, when?: ______/______/______
Do you have joint implants?	☐Yes	☐No	If yes, implant?: When?: ______/______/______
Have you had any serious illness?	☐Yes	☐No	If yes, illness?: When?: ______/______/______
Have you had surgery?	☐Yes	☐No	If yes, surgery?: When?: ______/______/______

THANK YOU! PLEASE BRING UP TO FRONT DESK WHEN COMPLETED ☺