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PATIENT INFORMATION

(Confidential Information---Important for Our Files and Your Heath)

SEX: ___MALE
___FEMALE

CELL:________________

PATIENT______________________________DOB________________TEL:________________

HOME ADDRESS______________________________CITY_______________ZIP________________

EMAIL ADDRESS______________________________SOCIAL SECURITY NO.________________

RACE________________ETHNICITY______________________LANGUAGE________________

MARITAL STATUS: ___SINGLE __MARRIED __LEGALLY SEPERATED __DIVORCED __WIDOWED

PATIENT EMPLOYED BY______________________________OCCUPATION________________

BUSINESS TEL.________________ MEDICAL INSURANCE________________________

ARE YOU THE INSURED?______________________OR THE DEPENDENT________________

INSURED'S NAME______________________________________DOB________________

MEDICAL HISTORY

FAMILY PHYSICIAN______________________________FORMER PODIATRIST________________

PLEASE LIST ALL MEDICATIONS WHICH YOU NOW USE:______________________________

____

____

PHARMACY______________________________PHARMACY ADDRESS________________________

LIST ALL ALLERGIES TO MEDICATIONS:____

____

WHAT PROBLEMS BRING YOU TO OUR OFFICE?______________________________________

____

FOR WOMEN: ARE YOU PREGNANT?____________ IF SO, HOW MANY MONTHS?________________

FAMILY HISTORY

INDICATE WHICH OF YOUR IMMEDIATE RELATIVES HAVE HAD ANY OF THE FOLLOWING DISEASES: (EXAMPLE: MOTHER, FATHER, GRANDMOTHER, ETC.)

CANCER________________________ DIABETES________________________
HEART TROUBLE________________________ HIGH BLOOD PRESSURE________________________
KIDNEY DISEASE________________________ MENTAL/EMOTIONAL DISEASE________________________
STROKE________________________ ARTHRITIS________________________

PATIENT HISTORY

PLEASE CHECK OFF "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS:

YES	NO	NATURE OF PROBLEM
___	___	ALLERGIES/HAY FEVER
___	___	ANEMIA
___	___	ARTHRITIS
___	___	ASTHMA
___	___	BLEEDING TENDENCY
___	___	BLOODY SPUTUM
___	___	CANCER
___	___	CHEST PAIN
___	___	CHOLESTEROL
___	___	CIRCULATION
___	___	CRAMPS IN FEET/LEGS
___	___	DIABETES
___	___	FAINTING/CONVULSIONS
___	___	FEVER
___	___	GALL BLADDER DISEASE
___	___	GOUT
___	___	HEADACHES
___	___	HEART TROUBLES
___	___	HEART MURMUR
___	___	HIGH BLOOD PRESSURE
___	___	HIV POSITIVE
___	___	JOINT PAIN/SORENESS
___	___	KIDNEY DISEASE/STONES
___	___	LIVER DISEASE/JAUNDICE
___	___	LOW BACK PAIN

YES	NO	NATURE OF PROBLEM
___	___	LUNGS(PNEUMONIA,TB,ETC)
___	___	MITRAL VALVE PROLAPSE
___	___	NIGHT SWEATS
___	___	NUMBNESS IN FEET/LEGS
___	___	PERSISTANT COUGH
___	___	PSYCHIATRIC
___	___	RECENT WEIGHT LOSS
___	___	SHORTNESS OF BREATH
___	___	SKIN
___	___	THYROID
___	___	TROUBLE WITH HEARING
___	___	TROUBLE WITH VISION
___	___	ANY OTHER PROBLEMS NOT LISTED PLEASE LIST HERE:

____
____
____

YES	NO	
___	___	NEVR SMOKED
___	___	FORMER SMOKER
___	___	CURRENT SMOKER
______		HOW MUCH DO U SMOKE?
___	___	DO YOU DRINK ALCOHOL?
______		HOW MUCH?

OPERATIONS / SERIOUS INJURIES	APPROXIMATE DATE	PHYSICIAN / HOSPITAL
________________	________________	________________
________________	________________	________________
________________	________________	________________

HAVE YOU PREVIOUSLY HAD PHYSICAL THERAPY? WHEN? WHERE? FOR WHAT CONDITION?
____

PATIENT SIGNATURE________________________ DATE________________
(IF MINOR, SIGNATURE OF PARENT OR GUARDIAN)