Mitchell Dalvin, D.P.M., 1749 S. Raccoon Rd., Austintown, OH 44515
(330) 799-3383

PATIENT INFORMATION SHEET

Name________________________________Age_________Date of Birth______________________

Address__________________________________Apt.#______E-Mail__________________________

City________________________State__________Zip________Home Phone____________________
Cell Phone ____________________
Patient's SS#________________________ Work Phone______________________

Male_______ Female_______ **Circle One:** Minor Single Married Divorced Widowed

Patient's or Parent's Employer_______________________________Phone______________________

Spouse or Parent's Name________________________________Employer______________________

Emergency Contact Name__________________________________Phone_____________________

Person Responsible for Account (patient or custodial parent of patient)_______________________________

Address if Different Than Above____

How Did You Know of Our Office?____

Primary Insurance____Insured Name________________

Insured Policy #_______________________________________Group #________________________

Insured Date of Birth________________________Relationship to Patient_______________________

Secondary Insurance______________________________________Insured Name________________

Insured Policy #_______________________________________Group #________________________

Insured Date of Birth_________________________Relationship to Patient______________________

SHOW ALL INSURANCE CARDS AND DRIVER'S LICENSE TO THE RECEPTIONIST

I authorize the release of any medical information necessary so that insurance claims can be processed.
I also authorize direct payment to Dr. Dalvin.

SIGNATURE____ DATE__________________

DR. MITCHELL DALVIN
1749 S. Raccoon Rd.
Austintown, OH 44515
(330) 799-3383

Medical History Form

Name________________________________ Age_____ Date of Birth_______________

Please list the main reason(s) you are here today, in order of importance:

____

Please circle "YES" or "NO" for the following questions:

Question	
Are you in general good health?	YES NO
Are you now or have you been under the care of a physician in the Past 2 years?	YES NO
Name of family physician:	
Have you ever had ill effects or allergic reactions from any medication? If so, please list medication(s):	YES NO
If female, are you pregnant now?	YES NO
Have you had any operations in your lifetime? If so, please list:	YES NO
Are you being treated for any illnesses? If so, please list:	YES NO
Have you had any injuries to the feet, ankles, or legs? If so, please list:	YES NO
Have you ever been hospitalized overnight? If yes, please list reasons:	YES NO

Have you been treated for any of the following? (Circle "YES" or "NO")

Condition		Condition	
Diabetes	YES NO	Kidney Ailment	YES NO
Heart Trouble	YES NO	Liver Ailment	YES NO
Stroke	YES NO	Thyroid Disease	YES NO
Cancer	YES NO	Stomach Ulcers	YES NO
High Blood pressure	YES NO	Rheumatic Fever	YES NO
Tuberculosis	YES NO	Epilepsy	YES NO

List all medications you are currently
taking:____
____

Pharmacy Name: ______________________________ Location: ______________________

Medical Review of Systems

Do you have or have you had within the past year (circle "YES" of "NO"):

Musculoskeletal

Joint pain, stiffness, or swelling If yes, where?	YES NO
Muscle cramps or spasms If yes, where?	YES NO
Backache	YES NO
Arthritis	YES NO
Rheumatoid arthritis	YES NO
Fibromyalgia	YES NO
Other conditions of muscles or bones If yes, please list:	YES NO

Integumentary

Changes in moles or skin lesions on the feet or ankles	YES NO
Do you form large scars (keloids)	YES NO
Rashes, psoriasis, non-healing skin sores(ulcers) or other skin condition If yes, what?	YES NO

Neurological

Unsteady walking	YES NO
Seizures	YES NO
Numbness or tingling on the feet or legs	YES NO
Other neurological problems If yes, please list:	YES NO

Cardiovascular

Have you ever had a heart attack? If yes, when?	YES NO
Chest pain	YES NO
Leg cramps If yes, do they occur when walking? day or night? how frequently?	YES NO
Swelling of feet or ankles	YES NO
Toes turn blue or hurt with cold exposure (Raynaud's)	YES NO
Mitral valve prolapse or other heart murmur If yes, have you been advised to take antibiotics prior to dental work	YES NO YES NO

Gastointestinal

Coughed up blood	YES NO
Chronic diarrhea	YES NO
Black tarry stools	YES NO
Ulcers	YES NO
Heartburn	YES NO
Hiatal hernia	YES NO
Colitis, Crohn's disease, or other gastrointestinal problem If yes, please list:	YES NO

Psychiatric

Depression, panic attacks, or other psychiatric problem If yes, please list:	YES NO

Constitutional

Significant weight gain or loss (more than 10 pounds)	YES NO
Fatigue	YES NO
General weakness	YES NO
Fever or night sweats	YES NO

Eyes, Ears, Nose, Throat, Mouth

Glaucoma	YES NO
Hearing loss	YES NO
Dizziness	YES NO
Other problems with eyes, ears, nose, throat, or mouth If yes, please list any known conditions:	YES NO

Respiratory

Shortness of breath	YES NO
Chronic cough	YES NO
Difficulty breathing or other respiratory problem If yes, please list any known condition:	YES NO

Genitourinary

Burning with urination	YES NO
Sexually transmitted diseases	YES NO
If female: Number of pregnancies: Number of births:	

Endocrine

Excessive thirst, hunger, or frequency of urination	YES NO
Ever had hepatitis	YES NO
Other problems with internal organs If yes, please list:	YES NO

Hematologic/Lymphatic

Sickle cell disease or trait	YES NO
Anemia	YES NO
Easy bruising or bleeding	YES NO
Hemophilia or any other problems with blood If yes, please list:	YES NO

Allergic/Immunologic

Lupus, scleroderma, or any other immune system problem If yes, please list:	YES NO

Family History

Has any blood relative had any of the following: (Circle "YES" or "NO", Leave blank if uncertain)

		Relationship
Diabetes	YES NO	
Gout	YES NO	
Heart disease	YES NO	
Sickle cell disease or trait	YES NO	

Social History

Do you drink alcohol? If yes, please circle: frequently occasional rarely Number of alcoholic beverages per week:	YES NO
Smoking Status: (**Circle one**) Current every day smoker, current some day smoker, smoker current status unknown, former smoker, never a smoker, unknown if ever smoked Packs smoked per week:	
Do you use other tobacco products?	YES NO
Do you use illegal drugs?	YES NO
If patient is child, how many brothers: sisters:	

Height____________ Weight____________ Blood Pressure____________

Primary Language: ☐English ☐Spanish ☐Other____________________

Race: ☐American Indian or Alaska Native
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

________________________ ______________
Signature of patient Date

________________________ ______________
Patient name (printed) Patient Number

I have reviewed this medical history:

________________________ ______________
Physician signature Date