

Welcome to *ADVANCED* PODIATRY

Patient Information

Date _____ Preferred 1st Name _____

Patient Legal Name _____
(Last) (First) (MI)

Address _____

City _____ State _____ Zip _____

SS# _____ E-Mail _____

Sex ? M F Age _____ Birthdate _____

Married Widow Single Minor Separated Divorced

Patient Employer/School _____

Empl/Schl Address _____

Empl/Schl Phone (_____) _____

Spouse's Name _____ DOB _____

Spouse's Employer _____

How did you hear about us? _____

Phone Numbers

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Phone #s H(_____) _____ Other (_____) _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co _____

ID & Group # _____

Is patient covered by an auxiliary insurance? Yes No

If yes:
 Subscriber Name _____

DOB ___/___/___ SS# _____

Insurance Co _____

ID & Group _____

Medications

Include prescriptions, over-the-counter medications & vitamins

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? Yes No

Allergies

Have you ever had an allergic reaction? Yes No

Please list all allergies you have _____

Podiatric History

What is the chief complaint for which you came to be treated? (Include foot, ankle, & leg complaints.)

Have you ever been to a podiatrist? Yes No

If yes, please list:
 Name: _____ Last Visit Date: _____

Is there any personal or family history of diabetes? Yes No

Your occupation: _____

Athletic activities in which you participate (include frequency): _____

Please indicate which foot problems you now have or have had in the past:

Ankle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns & Calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramp or Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flat Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heel Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ingrown Toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plantar Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen Ankles/Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wounds	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History

Place a mark if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies to Medicine/Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Foot/Leg Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves/Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling in Ankles/Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis/ Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Ear Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Other Medical Problems not listed (describe) _____

Surgeries you have had _____

Hospitalizations other than those listed _____

Primary Care Physician and Phone # _____ Last Visit Date _____

Family History

Check (√) if your blood relatives had any of the following:

√	Disease	Relationship to you
	Arthritis	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Gout	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Other	

Health Habits

Check (√) which you use and how much:

√	Substance	How much?
	Alcohol	
	Caffeine	
	Street Drugs (specify)	
	Tobacco	
	Other	

Comments regarding Health Habits: _____

The information that I have provided above and on the prior page is true and complete to the best of my knowledge.

Signature _____ Date _____