WEST SUBURBAN PODIATRY
DR. BRIAN ROZANSKI, DPM
DR. SEAN GOCKE, DPM
DR. PAUL SMITH, DPM

Patient Name _____

D.O.B. _____/_____/_____ Male _____ Female _____

Physical Address: _____ City _____ State _____ Zip_____

Mailing Address: _____City_____State_____Zip_____

Email Address: _____

Employer or School: _____ Work Phone (____) _____

Home Phone: (____) _____ Cell or Other: (____) _____

Emergency Contact Information

Name: _____

Phone: (____) _____

Relationship to Patient: _____

Patient Responsibility/Insurance

Insurance Company_____

Subscriber D.O.B. (if other than patient) ___/____/____

Subscriber name (if other than patient) _____

Local Pharmacy Information

Pharmacy Name_____ Location_____

Personal Contacts (ok to release personal health information to the following):

Name_____ Relationship_____

Name_____ Relationship_____

_____ _____
Patient Signature Date

West Suburban Podiatry

Patient Name: _____ Date ___/___/____

Height: _____ Weight: _____ Shoe Size: _____

Race: ___American Indian _____Asian _____Black/African American ____Caucasian

Ethnicity: _____ Hispanic ____ Non-Hispanic

Language: ____English ____Spanish _____ Other

Reason for visit: _____

Date of onset: _____

Primary Care Physician: _____ Date last seen:___/___/____

How did you hear about our office: _____

Medical History: (check only those items that apply)

____Diabetes: ___Insulin ___Oral Medication ___Diet Controlled When diagnosed ___/___/___

____Anemia
____High Cholesterol
____Peripheral Vascular Disease
____Arthritis
____Liver Disease
____High Blood Pressure
____Bleeding Disorders
____Stomach Ulcers
____Neuropathy
____Phlebitis
____Cancer
____Heart Disease
____Circulatory Problems
____Varicose Veins
____Hypothyroidism
____Autoimmune Disease
____HIV
____AIDS

____Athlete's Foot
____Arthritis
____Onychomycosis
____Plantar Fasciitis
____Ankle Pain
____Corns and Calluses
____Heel Pain
____Plantar Warts
____Gout
____Charcot Joint
____Leg Cramps/numbness
____Joint Pain
____Kidney Disease
____Epilepsy
____Hepatitis C
____CVA (stroke)

____Other not listed above _____

Surgical History (check only those that apply) Patient Name: _____

____Angioplasty
____Appendectomy
____C-Section
____Cataract
____Carotid Artery
____Gallbladder
____D&C
____Arterial Bypass
____Heart Bypass
____Open Heart
____Hysterectomy
____Hernia Repair
____Hip Replacement
____Knee Replacement
____Mastectomy
____Kidney Removal
____Kidney Stones
____Pacemaker
____Tonsillectomy
____Prostate
____Venous Ligation
____Breast Biopsy/Lumpectomy
____Back Surgery
____Foot Surgery (please indicate procedure) _____
Other: _____

Family History (please circle)

	Diabetes	Heart Disease	Cancer	High Blood Pressure
Mother	Yes	Yes	Yes	Yes
Father	Yes	Yes	Yes	Yes
Siblings	Yes	Yes	Yes	Yes

Social History:

____ Alcohol How often _____

Tobacco: Never ___ Former ___ Current/Every Day ____ Current/Some Days ____

Allergies (please circle): Novocain Aspirin Codeine Penicillin Cortisone

Adhesive Tape Latex Sulfa Other: _____