Name (Last, First, M.I.):_____

Birth date: _____ Gender (circle one): M F Social Security #: _____

The following information is now required by electronic medical record software and in no way will be used in a discriminatory manner.

Email: _____
Work #: _____ Cell #: _____
Home #: _____

Address: _____
_____
Apt #: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Primary Insurance Name: _____

Secondary Insurance Name: _____

Is this a work injury? : ☐ Yes ☐ No

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Address: _____
_____
_____

Ethnicity:
- ☐ Non-Hispanic
- ☐ Hispanic

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race:
- ☐ African
- ☐ Asian
- ☐ Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other: _____

Primary Care Doctor:

_____

Date last seen:

_____

Referred by:

SURGERIES: _____
_____
_____
_____

HOSPITALIZATIONS: _____
_____
_____
_____

INJURIES/ TRAUMA: _____
_____

FAMILY HISTORY: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer Type_____
☐ Other: _____

PATIENT SIGNATURE:_____ DATE:_____

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Name (Last, First, M.I.):_____

Reason for visit / Chief Complaint: _____

How long has this been present? _____ Have you seen a podiatrist before? ☐ Yes ☐

Height: _____ Weight: _____ Shoe Size: _____ Are you pregnant?: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Living Situation: ☐ Alone ☐ With Family/Friends ☐ Nursing facility / Rehab

Do you use: ☐ Alcohol ☐ Tobacco ☐ Illicit Drugs Occupation:

Do you currently smoke?: ☐ Yes ☐ No Packs per day?: _____ Years?: _____

If no, Have you ever smoked? ☐ Yes ☐ No Quit Date: _____

MEDICAL CONDITIONS:

☐ No known medical problems

☐ Diabetes Type ____
☐ High Blood Pressure
☐ Poor Circulation
☐ Heart Disease
☐ Kidney Disease
☐ Liver Disease
☐ Gout
☐ Heart Attack
☐ Stroke
☐ Stomach Ulcers
☐ Cancer
☐ Asthma
☐ Thyroid Disease
☐ Blood clots
☐ Anemia
☐ Dialysis
☐ HIV/AIDS
☐ Hepatitis
☐ Other: _____

MEDICATIONS: Dosage / How Often

☐ I don't take any medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS:

☐ I am not allergic to anything that I am aware of.

☐ Iodine ☐ Penicillin ☐ Aspirin ☐ Anesthesia / Novocaine
☐ Codeine ☐ Sulfa ☐ Cortisone ☐ Adhesive / Tape on the skin
☐ OTHER: _____

Explain in detail what happens when you are exposed to the above allergy:

_____
_____

Date this first occurred: _____

PATIENT SIGNATURE: _____ DATE:_____

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