Progressive Podiatry PLLC

Name: _____ Date: _____

Please answer all questions with a check that apply to you. Thank you.

PLEASE BE AWARE THAT WE DO NOT PARTICIPATE IN EITHER WORKERS COMPENSATION OR NO FAULT!

Left	Right	Reason for seeing Doctor today
		Pain
		Injury
		Fungal Nails
		Warts
		Ingrown Toenail
		Surgical Consultation
		Other

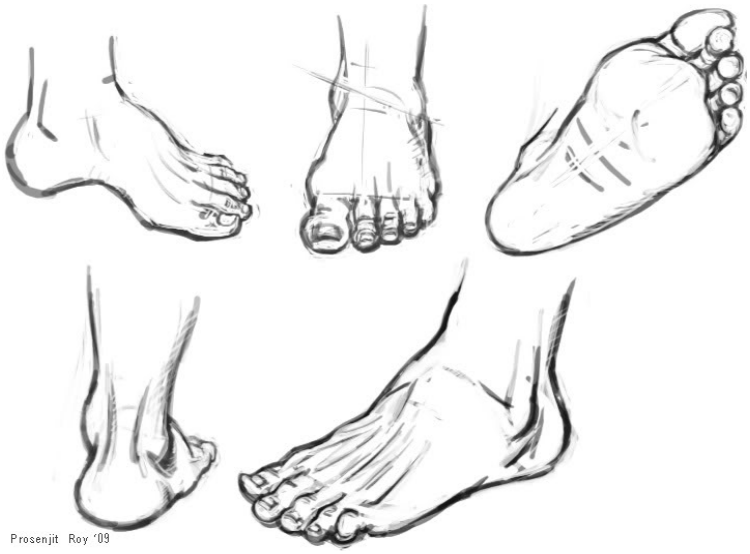
Do you have of the following?		Do you experience any of the following:	
	Bunions		Tingling
	Hammertoes		Shooting Pain
	Ulcers		Numbness
	Flat Feet		Stabbing Pain
	High Arches		Other:

Allergies	
	No Known Allergies
	Penicillin
	Shellfish
	Iodine
	Latex
	Other:

List of Medications
I am not presently taking any medications.

What is your normal shoe size? _____
How did you learn about us? _____
Height _____ Weight_____
Last recorded Blood Pressure _____

Please Circle area that causes you the most pain/discomfort.



Medical History	
	Diabetes
	High Blood Pressure
	Heart Disease
	High Cholesterol
	Gout
	Cancer
	Asthma
	Other Medical Conditions:

Family History			
	Mother	Father	Sibling
Diabetes			
Heart Disease			
Hypertension			
Cancer			
Gout			
Other:			

Surgical History	
Type	Year

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Race		Ethnicity	
	American Indian or Alaskan Native		Hispanic or Latino
	Asian		Non- Hispanic or Latino
	African American		Refuse to Report
	Native Hawaiian or other Pacific Islander		
	Caucasian		
	Refuse to Report		

Tobacco Use (for patients over the age of 13) Please check and then specify amount	
	Current Every day smoker
	Current some day smoker
	Former Smoker
	Never Smoked

Pharmacy Information:
Name of Pharmacy: _____

Address _____

Phone Number of Pharmacy: _____

Is there any other information that you would like to provide for the doctor at this time?

_____
_____
_____
_____

I give medical consent for Progressive Podiatry to electronically obtain all my medication history through my pharmacy. I have answered all questions regarding my medical history to the best of my knowledge and ability.

Name (Printed) _____

Signature _____ Date: _____