Robert J. Landy, DPM

Triple i / CliniForms

Patient Registration

Name _____ SS# _____

General Medical Information

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes ❑ Cigarettes ❑ Pipe ❑ Cigars No. of years _____ How much? _____

Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces/beers per day? _____

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? _____

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: _____

Personal Medical History

Have you ever had any of the following (check all that apply):

❑ Chest pain/pressure/tightening _____	❑ Asthma _____	❑ Kidney disease _____
❑ Hypertension _____	❑ Dizzy spells _____	❑ Shortness of breath _____
❑ Heart attack _____	❑ Cancer _____	❑ TB/Lung disorder _____
❑ Stroke _____	❑ Diabetes _____	❑ Ulcers _____
❑ Headaches _____	❑ Arthritis _____	❑ Skin disorders _____
❑ Glaucoma _____	❑ Difficulty hearing _____	❑ Hepatitis _____
❑ Allergies or Eczema _____	❑ Glaucoma _____	❑ Cataracts _____
❑ Depression _____	❑ Memory loss _____	❑ Digestive problems _____
❑ Blood in stool _____	❑ Hemorrhoids _____	❑ Frequent urinary infections _____

❑ Other: _____

Immunizations

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Eczema / Psoriasis	❑	❑	❑	❑	❑	❑
Heart attack / Stroke	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Hay fever	❑	❑	❑	❑	❑	❑

Miscellaneous Notes

Name _____