Welcome to Our Office!

This form will become a part of your medical record. Please fill out as accurately as possible. If additional space is required, please use back page.

Patient Information

Name: ____
First Name Last Name M.I.

Date of Birth: ________________________________
mm/dd/yyyy

Address: ______________________________________

____

Contact Numbers (mark preferred):

Home: ____

Cell: ____

Email: ____

Marital Status: Single Married Other

Gender: ____

Race/Ethnicity: ________________________________

Occupation: ____________________________________

Primary Care Doctor: ____________________________

Date of last visit: ______________________________
mm/yyyy

Emergency Contact

Name: ____
Relationship: ___________________________________
Phone #: ______________________________________

Insurance Information

Primary Insurance: ______________________________

Secondary Insurance: ____________________________

Medications

Do you currently take any medications? Yes No

If yes, please list all current medications, including prescriptions, over-the-counter, herbs, & vitamins. Please include the dose.

____

____

____

____

____

Do you take oral contraceptives? Yes No

Do you take any blood thinners? Yes No

Allergies

No Known Drug Allergies

Please list any medication allergies & reaction:

____

____

Are you allergic to any of the following?

Adhesive tape	Local anesthetic
Egg	Sea Foods
Latex	Sulfa
Iodine	

Preferred Pharmacy

Pharmacy Name: _________________________________
Address: _______________________________________
Phone #: _______________________________________

Referral

How did you hear about our office? _________________

____

Social History

Do you exercise? Yes No

If yes, briefly explain type of activity:

____

Do you drink alcohol? Yes No

Tobacco use? Current Former Never

If current, how many active years? _______________

If current, how many packs per day? _____________

If former, how many active years? _______________

If former, how many packs per day? ______________

History of illicit drugs/substance abuse? Yes No

If yes, what kind? ______________________________

Who lives with you in your household?

____

Family History

Please use an "X" to indicate if any of your family members have the following:

	Mother	Father	Sibling	Grandmother	Grandfather	Other
Alzheimer's/ Dementia						
Bleeding Disorder						
Blood Clot/ DVT/PE						
Cancer (if yes, type)						
Diabetes						
Heart Attack						
High Blood Pressure						
Osteoarthritis						
Rheumatoid Arthritis						
Stroke						
Other						

Surgical History

Have you had surgery? Never Yes

If yes, list any surgeries & year of operation:

____

____

____

____

Have you had any complications from surgery?

____

____

____

List any hospitalizations other than the surgeries listed:

____

____

____

Review of Systems

Do you now have, or have you RECENTLY had, problems with any of the following? Please circle your answers.

Fevers	Yes	No	Urinary Tract	Yes	No
Chills	Yes	No	Joint pain	Yes	No
Eyes	Yes	No	Skin rashes	Yes	No
Ears	Yes	No	Skin lesions	Yes	No
Nose	Yes	No	Migraines	Yes	No
Throat	Yes	No	Headaches	Yes	No
Teeth	Yes	No	Bleeding Disorder	Yes	No
Mouth	Yes	No	Blood Clots	Yes	No
Chest Pain	Yes	No	Blackouts	Yes	No
Heart	Yes	No	Falling	Yes	No
Lungs	Yes	No	Balance Problem	Yes	No
Short of Breath	Yes	No	Depression	Yes	No
Constipation	Yes	No	Seasonal Allergy	Yes	No
Diarrhea	Yes	No	Weight Loss	Yes	No

Medical History

Do you have, or have you ever had, any of the following MEDICAL PROBLEMS?

	Yes	No		Yes	No
Heart attack/Heart disease			*Rheumatoid Arthritis*		
High Blood Pressure			*Gout*		
High Cholesterol			*Seizures/Epilepsy*		
Diabetes			*Thyroid disease*		
Stroke			*Neuropathy*		
Asthma			*Peripheral Vascular Disease*		
Emphysema/COPD			*Blood Clot/PE*		
Gastric Reflux (GERD)			*Hepatitis*		
Osteoarthritis			*HIV/AIDS*		
Osteoporosis/Osteopenia			*Cancer*		

List details describing these or any OTHER medical problems/major hospitalizations you have or have had:
____
____
____
____

Lower Extremity History

What is the main reason for being seen today? ____________________________________
____

Which foot and/or ankle? Right Left Both

Quality of ailment? (Mark all that apply)

Aching Burning Shooting Radiating Dull Throbbing Constant

Sharp Tingling Stabbing Swelling Tender Pins/needles Intermittent

Other ____

Approximate date of onset of condition: ____

Known injury or trauma? ____

Severity of ailment? (Mark all that apply)

Getting Better Stays the Same Getting Worse Mild Moderate Severe

Prior treatments? ____

Has this condition been previously evaluated by a medical professional? If so, please explain:
____
____
____

Additional information: