

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	Medications				
Name: First Name Last Name M.I.	Do you currently take any medications? Yes No If yes, please list all current medications, including prescriptions, over-the-counter, herbs, & vitamins.				
Date of Birth: mm/dd/yyyy Address:	Please include the dose.				
Contact Numbers (mark preferred): Home:					
Cell:	Do you take oral contraceptives? Yes No				
Email:	Do you take any blood thinners? Yes No				
Marital Status: Single Married Other	Allergies				
Gender: Race/Ethnicity:	No Known Drug Allergies Please list any medication allergies & reaction:				
Occupation:	Are you allergic to any of the following?				
Primary Care Doctor: Date of last visit: mm/yyyy	Adhesive tapeLocal anestheticEggSea FoodsLatexSulfaIodine				
Emergency Contact	Preferred Pharmacy				
Name: Relationship: Phone #:	Pharmacy Name: Address: Phone #:				
Insurance Information	Referral				
Primary Insurance:	How did you hear about our office?				
Secondary Insurance:					



Social History

Yes

If yes, briefly explain type of activity:

No

Do you exercise?

 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/
 Image: Colspan="3">Image: Colspan="3"

 Mother
 Father
 Sibling
 Grandmother
 Grandfather
 Other

 Alzheimer's/
 Image: Colspan="3">Image: Colspan="3"
 Image: Colspan="3">Image: Colspan="3"

Do you drink alco	ohol? Ye	s 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 y	ou in your he	ousehold?						

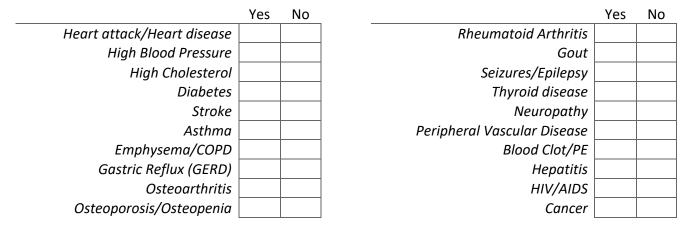
	Mother	Father	Sibling	Grandmother	Grandfather	Other
Alzheimer's/ Dementia						
Bleeding Disorder						
Blood Clot/ DVT/PE						
Cancer (if yes, type)						
Diabetes						
Heart Attack						
High Blood Pressure						
Osteoarthritis						
Rheumatoid Arthritis						
Stroke						
Other						

Surgical History	Review of SystemsDo you now have, or have you RECENTLY had, problems with any of the following? Please circle your answers.					
Have you had surgery? Never Yes If yes, list any surgeries & year of operation:						
	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
Have you had any complications from surgery?	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
List any hospitalizations other than the surgeries listed:	Heart	Yes	No	Falling	Yes	No
List any hospitalizations other than the surgeries listed.	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?



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 ailme	nt? (Mark al	l that apply)						
Aching	Burning	Shoot	ing	Radiating	Dull	Throbbing	Constant		
Sharp	Tingling	Stabb	ing	Swelling	Tender	Pins/needles	Intermittent		
Other									
Approximate da	te of onset o	of condition	:						
Known injury or	trauma?								
Severity of ailment? (Mark all that apply)									
Getting Better Stay		ays 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: