



## PODIATRY NEW PATIENT FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Endocrinologist: \_\_\_\_\_

Nephrologist: \_\_\_\_\_ Rheumatologist: \_\_\_\_\_

Please describe your problem (include date of injury if applicable)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Personal Medical History

Check those that apply

Frequent Headache/Migraines	Anemia/Blood Disorders
Rheumatic Fever	Pneumonia
Kidney Disease	Drug/Alcohol Abuse
Dialysis M W F or T TH SA	Epilepsy or Seizures
Diabetes Average Blood Sugar _____	Prolonged Bleeding Time
Tuberculosis	Stomach/Ulcer Disorder
Emphysema	Thyroid/Parathyroid Disease
Heart Trouble	High Blood Pressure
Stroke	Arthritis
Chest Pain on Mild Exertion	Psychiatric Treatment
Gout	Emotional Problems/Tension
BLOOD CLOTS	Asthma/Hay Fever/ Shortness of Breath
Tumor/Abnormal Growth/Cancer	Sexually Transmitted Disease
Ear, Nose, Throat Disorder	Prostate Disorder

**Has any family member had any of the following (please indicate relationship)**

Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Heart Trouble: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Mental or Emotional Disease: \_\_\_\_\_

Stroke: \_\_\_\_\_

Tuberculosis: \_\_\_\_\_

Arthritis: \_\_\_\_\_

Emphysema: \_\_\_\_\_

BLOOD CLOTS: \_\_\_\_\_

## Patient Information

Do you smoke currently?  Yes  No How many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you smoked previously?  Yes  No When did you quit? \_\_\_\_\_

Number of caffeine drinks per day? \_\_\_\_\_ Amount of alcohol consumed per week \_\_\_\_\_

### Please complete the following:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe size: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Exercise: Type, duration, and frequency (example: walking 30 minutes 3 x/week)

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## Allergies

Please check all allergies:

Medications: \_\_\_\_\_

foods: \_\_\_\_\_

Tapes  Novocain  Anesthetics  Silver/Nickel/Costume Jewelry  Other: \_\_\_\_\_

What types of reactions have you experienced?

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## Medications

Please list all medications and the dosages:

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## Surgical History

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature