PODIATRY NEW PATIENT FORM

Name:_____Date of Birth:_____

Primary Care Physician (PCP):_____Date Last Seen by PCP:_____

Please describe your problem (include date problem first occurred or was noticed)

_____

_____

_____

PERSONAL MEDICAL HISTORY

Check those that apply

	Frequent Headaches/Migraines		Stomach Ulcers
	Kidney Disease		Thyroid Disease
	Dialysis (if yes, how often_____)		High Blood Pressure
	COPD		Neuropathy
	Heart Attack		Rheumatoid Arthritis
	Heart Disease (Coronary Artery Disease)		Osteoarthritis
	Chest Pain		Anxiety
	Stroke		Depression
	Diabetes		Asthma/Shortness of Breath
	Gout		Prostate Disorder
	Blood Clot (DVT)		AIDS/HIV
	Cancer (if yes, type_____)		Fibromyalgia
	Anemia/Other Blood Disorder		Multiple Sclerosis
	Drug/Alcohol Abuse		Glaucoma
	Seizures		Macular Degeneration
	Peripheral Vascular Disease (PVD,PAD)		Other:
	Varicose Veins/Venous Insufficiency		Other:

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

Medical Problem	Family Member	Living or Deceased
Cancer		
Diabetes		
High Blood Pressure		
Heart Attack		
Stroke		
Other:_____		

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PATIENT INFORMATION

Do you currently smoke? Yes No How many packs/day? _____ How many years? _____

Did you previously smoke? Yes No How many packs/day? _____ How many years?_____ Year Quit?_____

Do you consume alcohol? Yes No If yes, how many drinks per week? _____

Do you use any illicit drugs? Yes No If yes, which drugs and how often? _____

Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Other

Dwelling type? ___Single Family Home ___Apartment ___Assisted Living ___Nursing Home ___Other (_____)

Do you live alone? Yes No Does your home require the use of stairs? Yes No

Do you receive home health care? Yes No If yes, agency name_____

Exercise: Type: _____ Frequency? _____

ALLERGIES

Penicillin Sulfa Codeine Tape Latex Iodine Lidocaine/Novocain Silver

Other Medications: _____

Foods_____

SURGERIES/PROCEDURES

Surgical Procedure	Year

MEDICATIONS

Medication	Frequency	Medication	Frequency	Mediation	Frequency

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HEALTH REVIEW

Please circle the symptoms you have had in the past 3 months:

General	Fever Chills Fatigue Weight Loss Weight Gain
Head	Headaches Blurred Vision Double Vision Hearing Loss Ringing in Ears
Cardiovacular	Chest Pain Dizziness Leg Pain Leg/Foot Cramps Swelling of Legs
Hematomlogy	Blood Clots Anemia Abnormal Bleeding or Bruising
Respiratory	Persistent Cough Shortness of Breath Wheezing
Musculoskeletal	Joint Pain Joint Stiffness Arthritis Back Pain Muscle Weakness
Dermatological	Rash Itching Ulcers/Sores Suspicious Lesions Corns Calluses Discolored Toenails Thickened Toenails
Neurological	Numbness of Legs or Feet Tingling/Burning of Legs or Feet Seizures
Psychiatric	Anxiety Depression Memory Loss Difficulty Sleeping
Endocrine	Thirsty Frequent Urination Heat/Cold Intolerance Change in Skin/Hair Texture
Other	List Symptoms:_____

The information provided here 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. This information will be kept confidential and only used or shared with other medical personnel to assist with diagnosis and/or treatment.

Patient Signature: _____ **Date**: _____

If completed by someone other than the patient, please indicate your name, relationship and sign below:

Name: _____

Relationship: _____

Signature: _____

Date: _____

PERSONNEL USE ONLY

I have personally reviewed the above information.

Physician Signature: _____Date: _____