NEW PATIENT INFORMATION

LAST________________________FIRST________________________MIDDLE_________________________

D.O.B_____________AGE_________SEX_________MARITAL STATUS____ SS#_________________________

HOME PHONE____________________CELL______________________E-MAIL_________________________

ADDRESS______________________________________CITY_____________STATE__________ZIP__________

MAILING ( ) CHECK BOX IF SAME AS HOME
ADDRESS______________________________________CITY_____________STATE__________ZIP__________

NEXT OF KIN OR EMERGENCY/ALTERNATE CONTACT: Name________________Cell_____________E-mail__________

EMPLOYER___________________LOCATION_________________________PHONE_____________________

PRIMARY CARE DOCTOR______________________PHONE_________________LAST VISIT_______________

SPOUSE/
GUARDIAN_______________________ADDRESS_____________________CITY_____________________

STATE__________ZIP____________PHONE_____________SS#______________________________(SPOUSE)

SPOUSE EMPLOYER________________________ADDRESS_____________________PHONE______________

INSURANCE INFORMATION

INFORMATION OF PERSON NAMED ON THE INSURANCE CARD AND THEIR RELATIONSHIP TO PATIENT

NAME_______________________RELATIONSHIP________________________PHONE__________________

ADDRESS__________________________SS#____________________BIRTHDAY_______________________

PERSON RESPONISBLE FOR BILL (MUST BE COMPLETED)
( )CHECK IF SAME AS PATIENT

NAME_______________________________________SS#__________________BIRTHDAY________________

ADDRESS___________________________CITY______________________STATE_______________________

PLEASE PROVIDE THE RECEPIONIST WITH TH FOLLOWING DOCUMENTS FOR COPYING:

PRIMARY INSURANCE CARD **SECONDARY INSURANCE CARD** **DRIVER LICENSE or PHOTO ID**

SIGNATURE____DATE___________________________

New Patient Health History

Patient Name: ______________________________ DOB: ______________ Date: ______________________

Please Describe Your Current Foot Problem

____
____
____
____

Please Check All That Apply

Cardiovascular:
- o Ankle swelling
- o Calf cramping
- o Change in color/temp extremity
- o Chest pain or tightness
- o Shortness of breath

Immuno/Hemo:
- o Bleeding tendencies
- o Clotting difficulties
- o Environmental allergies
- o Gouty attacks
- o Viral infections

Integument:
- o Blisters
- o Dry/scaly skin
- o Ingrown nail
- o Itching
- o Foot ulcers
- o Slow-healing

Neurological:
- o Burning tingling
- o Hypersensitivity
- o Numbness
- o Paralysis
- o Tremors
- o Vertigo

Endocrine:
- o Cuts take longer to heal
- o Excessive urination
- o High blood sugar
- o Low blood sugar
- o Unusual Fatigue

Gastro:
- o Diarrhea
- o Liver disease
- o Nausea
- o Reflux
- o Vomiting

Lymph:
- o Enlarged node
- o Leg swelling
- o Cancer

Psychiatric:
- o Anxiety
- o Depression
- o Memory loss
- o Panic attacks

Eye/ENT:
- o Difficulty swallowing
- o Hearing loss
- o Legally blind
- o Retina disease
- o Sinus infection/congestion

Urinary:
- o Blood in urine
- o Dysuria/Nocturia
- o Frequent urination
- o Weak bladder
- o Weak kidney

Musculoskeletal:
- o Back pain
- o Decreased Rom
- o Heel pain
- o Joint pain
- o Morning stiffness
- o Weakness

Respiratory:
- o Asthma
- o Breathing difficulty
- o Cough
- o Shortness breath
- o Smoker

Surgery/Hospitalizations:

____
____
____
____
____

Medical History:
Medical Problems

____
____
____
____
____

Medications:
Prescription and OTC

________________ ________________
________________ ________________
________________ ________________
________________ ________________
________________ ________________

Your Pharmacy: ________________________

Allergies

Penicillin	Sulfa	Aspirin
Codeine	Iodine	Shellfish
Tape	Latex	IVP Dye

No Known Drug Allergies (NKDA)

Other: __________________

Family Health History

____
____
____
____

Social History:

Tobacco: **Yes** ____Pk/day ____Yrs. **No**

Alcohol: **Yes** #drinks per day:______ **No**

Illicit Drug Use: **Yes** **No**