FOREMOST PODIATRY

COMPREHENSIVE FOOT AND ANKLE CARE

PODIATRIC REGISTRATION AND HISTORY FORM

Date _____ **Patient Name** _____ **SSN** _____

Date of Birth _____ **Age** _____**Gender** _____ **Who referred you?** _____

Patient Address_____

_____

E-Mail _____

Can we send you email with health care and appointment information? Yes or No

Mobile Phone _____

Home Phone_____ **Work Phone** _____

Preferred Contact Method (Circle) Mobile, Work, Home, Email

Emergency Contact

Name _____ **Relationship**_____ **Phone** _____

Address _____

Can we discuss your personal health information with this person?_____

Allergies – Please state the symptom and severity

_____

Medications - include over the counter, herbals, and birth control (can attach list):

_____

_____

What is the name and location of your preferred pharmacy? _____**Zip Code** _____

Height_____ **Weight**_____ **Shoe Size**_____

List your primary care physician _____

Last appointment date? _____

What is your occupation and how much time do you spend on your feet at work?

_____

What type of athletics and/or regular exercise or activities are you involved in?

_____

Do you smoke? If yes, than for how many years? How many packs per day?

_____

Do drink alcohol on a regular basis (specify type and amount)?

_____

Please tell me a about your foot or ankle problem (when it started, treatments you have tried etc.)?

_____

_____

Has there been any recent hospitalizations or new medical problems since your last appointment?

_____

Do you have or have you had any of the following:

_____

- ☐ Heart Disease
- ☐ Endocarditis (Heart valve infection)
- ☐ Hemodialysis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pre-Diabetic or Diet controlled Diabetes
- ☐ Diabetes controlled with oral medication
- ☐ Diabetes requiring Insulin
- ☐ Type I Diabetes
- ☐ Poorly controlled Diabetes
- ☐ History of DVT (deep vein thrombosis) or Blood Clot
- ☐ PE (pulmonary embolism)
- ☐ Clotting Disorder (factor V etc.)
- ☐ Prosthetic Joint(s) or Heart Valve Replacement
- ☐ HIV or AIDS
- ☐ Hepatitis C
- ☐ GERD (acid reflux)
- ☐ Stomach Ulcer or other GI Ulcer
- ☐ Skin Cancer or Melanoma
- ☐ Take Blood Thinners
- ☐ Stroke or CVA
- ☐ Peripheral Vascular Disease (PVD/PAD/ASO)
- ☐ Peripheral Neuropathy or Numbness in the Feet
- ☐ Foot Ulcer
- ☐ Foot Infection
- ☐ Rheumatoid Arthritis
- ☐ Other Auto-Immune Disease (Psoriasis, Lupus etc.)

Do you have any other medical problems? _____

Please list any previous surgery and approximate dates: _____

_____

Is there a history of diabetes, blood clots (DVT/PE), clotting disorder, or cancer in your family? (please specify)

_____

Female Patients: Do you take oral contraceptives or use implantable or injectable birth control? _____

Female Patients: Are you pregnant? _____

I certify that the information on the front and back of this sheet is true and accurate to the best of my knowledge:

Signature _____**Date** _____ **Guardian**_____ **Date**_____